

THE SUBLUXATION SPECIFIC—
THE ADJUSTMENT SPECIFIC

PALMER

THE
SUBLUXATION
SPECIFIC-
THE
ADJUSTMENT
SPECIFIC

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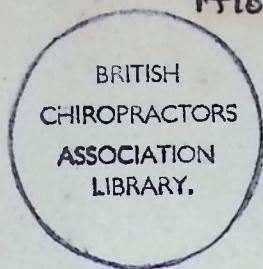
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WORLD-EUROPEAN COLLEGE OF CHIROPRACTIC

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It was and has been a duty
and pleasure to be sincere in
upholding my father's gift
to humanity. I hope you can
and will continue what
is given you in these pages.

FD

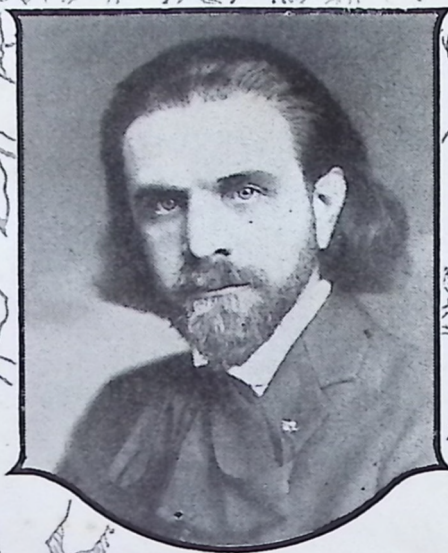
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CHIROPRACTIC

B. J. PALMER, D. C., Ph. C.

(Son of D. D. Palmer)

Developer of Chiropractic
and President of
The Palmer School
of Chiropractic



D. D. PALMER

Discoverer of Chiropractic

Founder of

The Palmer School
of Chiropractic



The PALMER SCHOOL *of* CHIROPRACTIC
CHIROPRACTIC FOUNTAIN HEAD DAVENPORT, IOWA, U. S. A.

The Subluxation Specific— The Adjustment Specific

"In science, the thing is to modify and change
ones ideas as science advances."

—Claude Bernard.

"At this very hour, the World is seething with
unrest in its search for not a specialist in this,
that, or the other, but a specialist in man-
kind as such, who views man as combined of
spirit, soul, and body; and recognizes that the
inter-action of the three is so close that they can
never touch one without touching all three."

Alexander Cannon. in
"The Invisible Influence."

AN EXPOSITION *of the* CAUSE OF ALL DIS-EASE



By

B. J. PALMER, D. C., Ph. C.

Developer of Chiropractic

Discoverer of The Specific for the Cause of All Dis-ease

President, The Palmer School of Chiropractic

CHIROPRACTIC FOUNTAIN HEAD

Davenport, Iowa, U. S. A.

IN ENTERING into the study of this book and its work, each should, so far as possible, lay aside for the time being all previous theories, beliefs, teachings, and practices. By so doing, you will be saved the trouble of trying, all the way thru, to force "new wine into old bottles." If there is anything, as we proceed, which you do not understand or agree with, let it lie passively in your mind until you have studied and gone thru the book the THIRD time, for many statements that would at first arouse antagonism and discussion will be clear and easily accepted further on, after mature reflection and after repeated understanding. After you have given the book mature deliberation, if you wish to return to your old beliefs and ways of living, you are at perfect liberty to do so. But, for the time being, become as little children; for, said the Master, "Except ye become as little children, ye can in no wise enter the kingdom of heaven".

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**The Palmer School of Chiropractic
CHIROPRACTIC FOUNTAIN HEAD
Davenport, Iowa, U.S.A.**

The Palmer School of Chiropractic, Publishers

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COLONEL B. J. PALMER
Lieut.-Colonel, A.D.C.
Governor's Staff (Iowa)



DOSSA DIXON EVINS, D.C.
Inventor and Developer of Neurocalometer
Born February 13, 1886; Died November 15, 1932

Dedication



PRIMO

This is written Christmas Day, 1933. We retrospect contemplatively.

Any man in public life meets many strangers, amongst whom he picks up many acquaintances. A few will call themselves his friends, amongst whom he calls a few chosen. Eventually, he culls even those who prove themselves worthy. Many have "ideas"; one of a thousand of more than passing merit; one of a million with a message of service.

It is said that "blood is thicker than water." All depends upon whose blood, or water, it is. Relatives may be closest of kin, but they can prove to be thinner than water sometimes. It depends upon the tie that binds. Now and then an outsider, with kinship in no way, perhaps a total stranger, enters and becomes closer than any Damon and Pythias.

Such a stranger was Dossa D. Evins who entered the life of B. J. Palmer. He came as a patient, who regained health. Then he became a student-follower. He graduated and became a loyal practicing Chiropractor. He developed, invented and patented the Neurocalometer and proposed it to our profession. By so doing, he entered our personal, as well as professional family.

Thru ten years of labor pains, its childhood with ambiguities, its young manhood with childish mistakes, Dossa D. Evins stood hard-by during storm and stress. He was a Captain on the ship in deep and rough waters. He proved himself rugged and true.

He came. He delivered. He passed away while his work was in progress and before it had arrived. We have aimed to carry on in his memory, that which he would have desired we do.

It is fitting that this work—his work—the accumulation of results of his product; that which sequentially followed the use of his NCM, should be dedicated to him.

So long as the Neurocalometer is, the name of Dossa D. Evins will be a household thanks. Millions of lives, with their added millions of years, have been and will be saved because of him.

Dossa D. Evins may be dead in the flesh, but no man dies whose ideals live! Dossa D. Evins' NCM lives!

This book is as much Dossa D. Evins' as it is that of the Author; but we dedicate it to him because he crossed the bridge ahead of us.

SECONDO

1934 years ago, the Master had twelve disciples. One thrice denied Him. One betrayed Him.

1934 years later, the birth and development of The Specific of The Cause of Dis-ease also had its small group of disciples who huddled about its discoverer. There were those who thrice denied its birth, babyhood, boyhood. There was one who betrayed its personal and professional origin and message.

There were those of the PSC Faculty who remained steadfast and true, thru all its trials, troubles, and tribulations; confident in the leadership and his outcome, to lead them to the promised land of the Grand Objective.

To this loyal group we also dedicate this work as a tribute to their vision and courage, even tho constantly engendered during those dark days, when only one knew the ultimate and where it led all out of the wilderness.

TRIO

There are circles outside of circles.

1st. There was B. J. Palmer at the very center or hub of things Chiropractic.

2nd. There was a close-in circle outside of that point that embodied D. D. Evins.

3rd. There was a circle just outside of that, which consisted of those Faculty Members whom we have accredited under "Secondo."

4th. In a larger sense, just outside that group was our family of Chiropractic children—those born at the PSC and migrated to the four corners of the earth.

Some of our children denied their parentage. Some denied the parents but were always found with their feet under the feed trough when Chiropractic food worth while was being handed out free. But there did exist a great big group that remained

loyal to their Alma Mater thru its ups and downs; and to those we now pay tribute with our appreciation of their constant loyalty and correspondence that helped smooth rough waters when misunderstandings were rife and malicious rumors were common gossip. May Innate continue to bless their vision with understanding and encouragement to keep them keeping on.

QUARTO

The first shall be last and the last shall be first!

My Mabel and my Dave who lived with me thru these years of trying times, when and where home life meant a constant reiteration, rededication, and reconsecration to those things for which we had sacrificed all we held dear. Living these troublesome years and sharing our joys; breathing, eating, drinking, and talking these problems and their developments, comes most to those who are in the family circle. They alone, of all concerned, really realize their truest meaning and values. They are pals of every second of every year. They ALONE know how I appreciate what their frank counsel has meant!

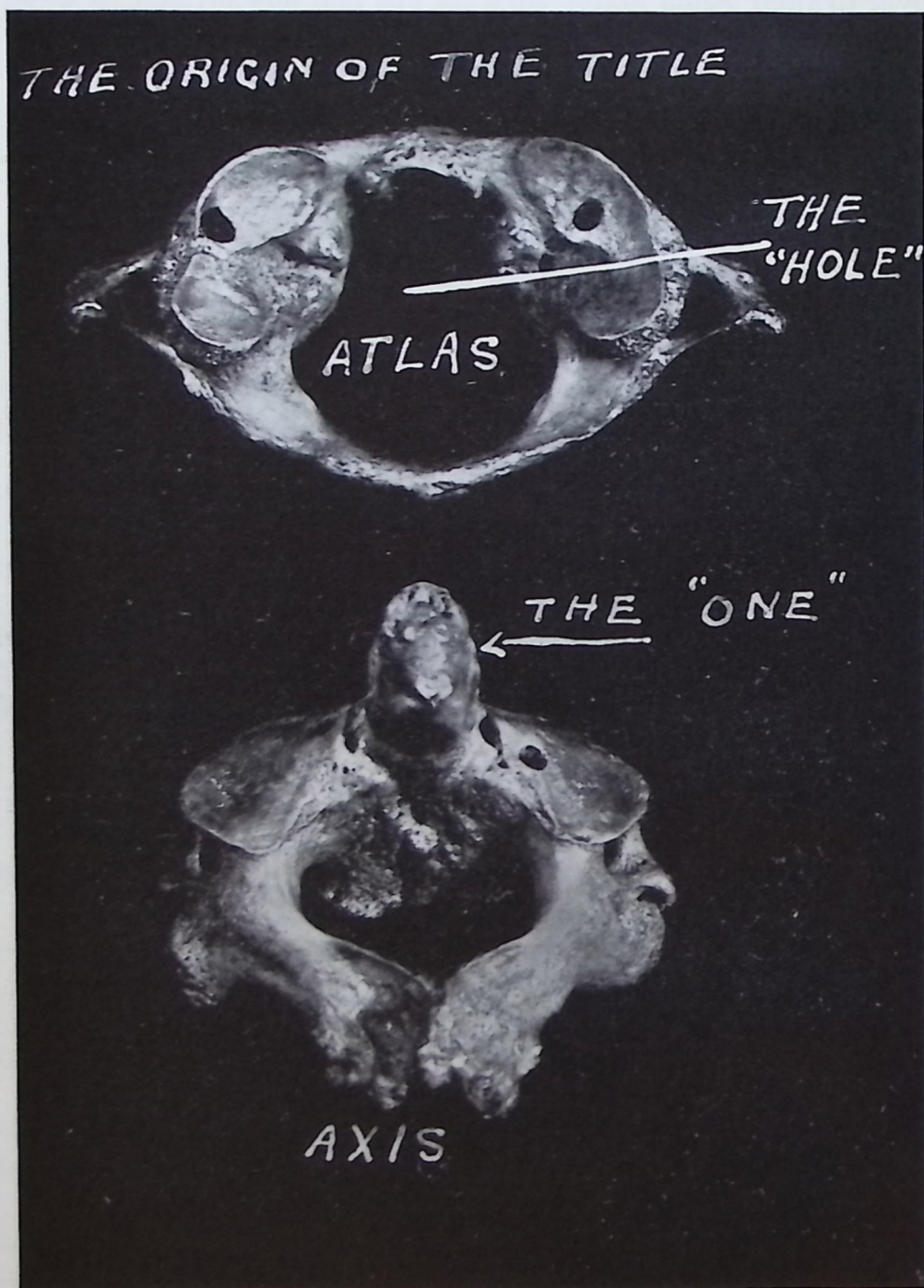


Illustration No. 1

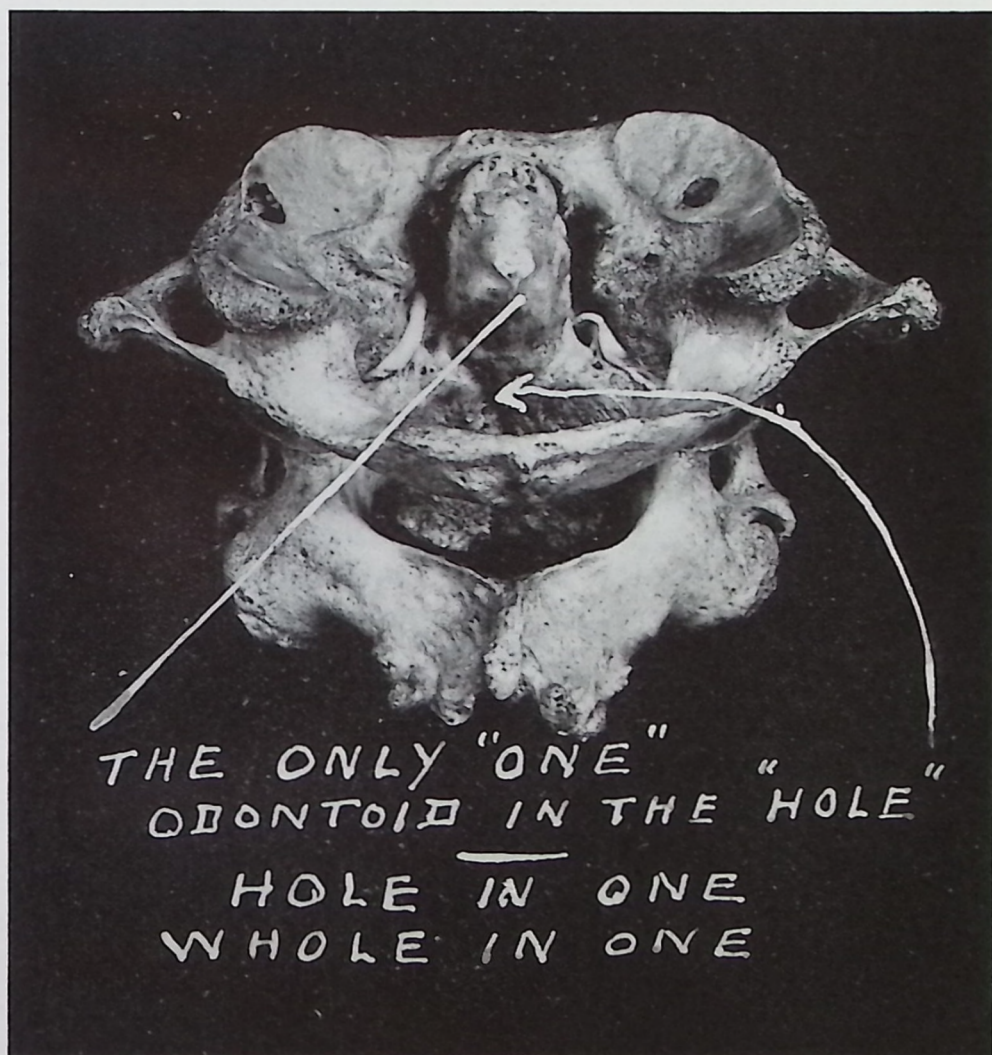
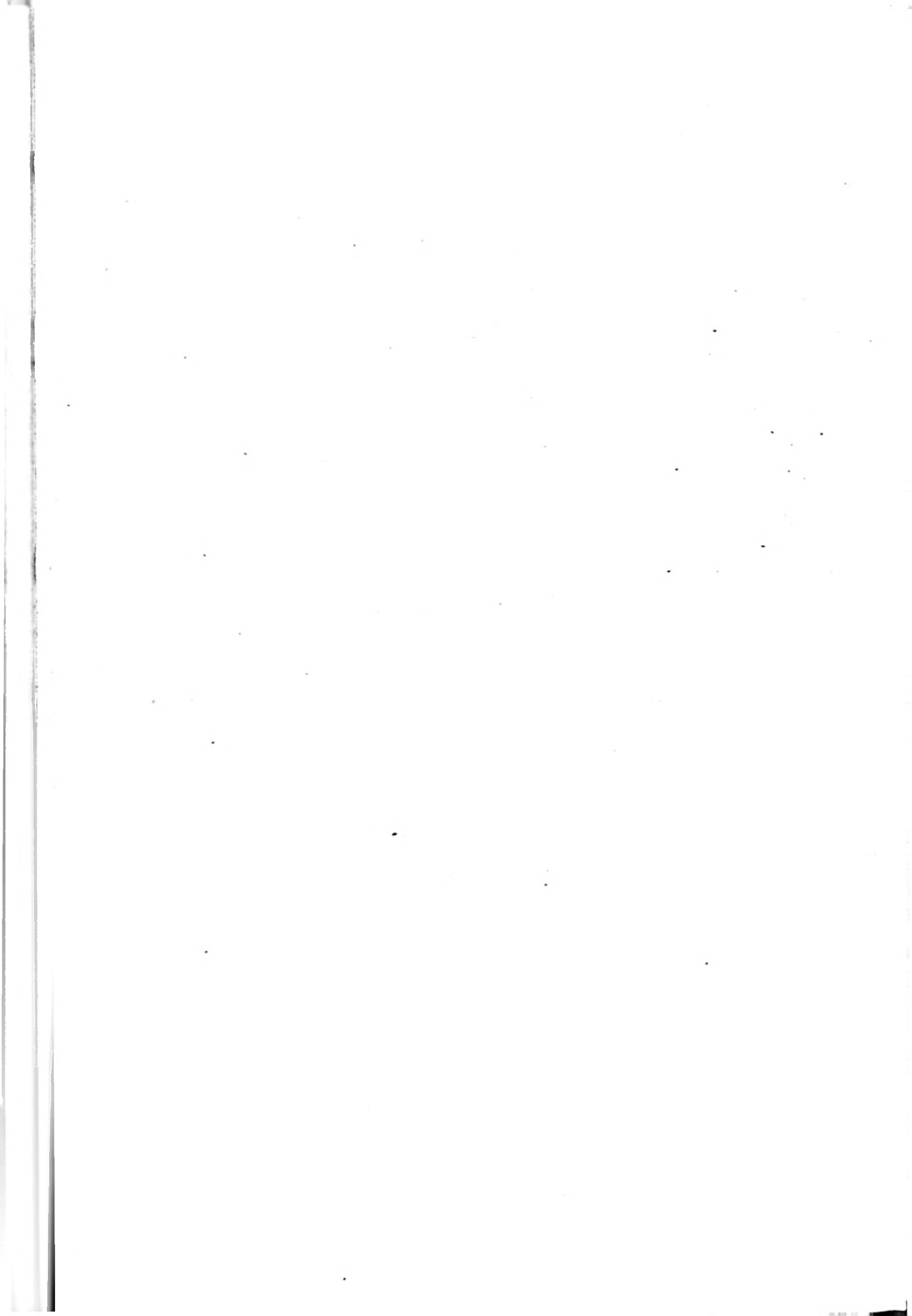


Illustration No. 2



Preface



IN preparing this book, we have presented that work which has not seen print in other of our works. After studying this, there are going to be many questions unanswered in the minds of students. Answers may be found in our other works; or we do not yet know it. We suggest the student get other works, study them; THEN if the answer is not forthcoming, write and we will endeavor to work it out.

During 11 years since introduction of NCM, we have been gradually climbing the scale of understanding of much that before was mystery. We have left behind much theory and taken on much science. As developments occurred, we have written them into our publications. The past few years we have issued an annual of research work of year previous. To bring this book to its fullest value, would mean to reprint most of those into this. As those productions ARE in print, and can be had as separate units, we do not feel the necessity of reprinting and incorporating them into this.

We list those productions, with price:

1. Manual of Instruction in Gliding Technique for Use of NCM No. 2. (Being republished in spring of 1934)
Issued to lessees with NCM Contract.
2. Reasons For My Faith
(A booklet of Lecture of Evolution of Chiropractic with Many of Its Facts.)
Price\$.10
3. A Hole in One
(A lecture for lay people, being an exposition of the new Chiropractic principle and practice.)
Price10
4. The Hour Has Struck
(A talk delivered Lyceum 1924, when NCM was introduced)
Price10
5. Why Did B.J. ?
(A book of explanations of early problems of NCM. Produced in 1925 to answer many derogatory statements against NCM.) (Out of print)

6. The Hour Has Arrived
(A book of scientific articles revealing developments re NCM. Issued Lyceum 1931.)
Price50
7. Crowding The Hour
(A 192-page book of scientific development re NCM. Issued Lyceum 1932.)
Price 1.00
8. Disciplining The Hour
(A book of scientific developments re NCM. Issued Lyceum, 1933.)
Price 1.00

We have not, in this publication, gone into the intricacies of technique of

How to use NCM

How to expose spinographic plates

How to develop spinographic plates

How to build up a Chiropractic adjustment,

believing those details are matters of instruction in a school devoted to that subject, where time can be spent pursuing the course essential to production and building of a Chiropractor. In no sense, then, is this book a substitute for a Chiropractic course of instruction. It does, however, aim to present ground-work in fundamental principles in latest development of the Chiropractic principle and practice.

This book epitomizes the essence of the change for the before-NCM-days to the Specific HIO step upward.

We appreciate that this book opens a new trend of constructive proof of Chiropractic. That there is much to be learned, is obvious; that there is much buried to be dug out, is well known; that we may have made mistakes in the production of this work is quite possible. We appreciate suggestions, aid, and help in more clearly presenting our truths.

Every new art, of the newness of that covered in this work, is in a state of evolution which covers years of development. We have constantly been passing it on to our profession in various stages of its growth. Many persons have attended our classes, some of whom have gone forth with perhaps only a partial understanding of what we then taught. Now and then one has claimed to be our "representative", offering some of our constructions in

misunderstood, even tho sincere, form; some even going so far as to claim originality for them. Wherever there is truth there is counterfeit; where there is a possible full understanding, there is also partial. That wrongly interpreted views can do harm from which sick are eventual sufferers, is obvious. That incomplete instruction is dangerous, is apparent. That incomplete, misunderstood, garbled conclusions have been delivered, is observable in our ranks, even now. Quality knowledge seeks its own level; understanding arrives at source, and that the profession as a group-mind arrives at a proper disposition of its loyalty, is positive. We offer this idea with a desire that instruction be wide-spread, but with the hope that our professional brethren will discriminate between spurious impostors who seek to financially aid themselves with little regard to professional welfare, and those who do honestly and sincerely desire to render a competent, accurate, efficient and complete service to mankind.

Now that sincere chiropractors, interested in the future scientific advancement of Chiropractic, have been presented with this torque sublaxation and torque adjustment idea, I find them thinking and practicing it seriously. As a result, we are receiving suggestions as to interpretations, methods of adjustment, etc., to improve understanding and to accomplish the objective it brings about. ONE THING, HOWEVER, IS ALMOST INVARIABLY OVERLOOKED; viz.: that a torque is a cork-screw, THREE DIRECTION motion. (1) Superior or inferior (2) circular (3) obliquely upward or downward direction. A torque kink, twist or wrench sublaxation was because the concussion of forces forced it from normal apposition articulations with vertebrae above and below, IN THREE DIFFERENT DIRECTIONS. Some chiropractors, who offer these constructive suggestions, have overlooked that a torque adjustment MUST comprise THREE directions, in the correctional movement. They fail to see that you can't PULL a cork out of a bottle, straight up. Every man who "pulls a cork" with a cork-screw, gives it a THREE directional pull. It is common, now, to receive suggestions that include one, sometimes two directions; but almost always the suggestions fail to INCLUDE THE THIRD which completely changes the value of whatever it is they suggest. We suggest our fellow-workers go slow in offering

suggestions until they have thoroughly tried the present idea and then if they find it fails, will be time enough to "originate" something better.

This request of "advance slowly" is odd, coming from one who has prodded his profession to grow, expand, keep physically plastic and mentally elastic, as fast as progress was made in Chiropractic philosophy, science, and art.

The average Chiropractor (and it is true of others) possesses a limit to his capacity for growth. The majority do not move unless shoved; do not think unless forced. Millions grow physically, even if below par; and stagnate mentally, even if slowed down. Many a person walks in a body 50 years old, with a mind not over 20 years developed, and running in low, slow gear. The physical development, even tho held back by subluxation, is running ahead of the mental status, per year. Innate governs physical growth, limited only by subluxation interference. Educated man cannot interfere in physical development. On the reverse, Educated exercises voluntary control to develop itself, and most Educated personalities stifle themselves by quickly reaching their capacity for expansion. When that Educated limitation is abnormally fixed the normal balance of his mental days lives like a youth, challenging advancement beyond understanding ahead of him. "Wait for me" is his challenge to Progress.

Thousands of Chiropractic students have passed in review, in school and since going to work in offices. They came here high with aspirations; they studied here with perspiration; they graduated with inspiration; they practiced with expiration. I have seen minds develop—some more, others less. Some grew so-so, others stagnated. To others, it was a new world. I have seen all develop to a certain point—and then stop. That stop sign might be during their school period, reach its pinnacle at graduation, it might be a year after they started practicing, or a few years after. The brain cup appears easily filled to overflowing; it can absorb no more; it has reached the saturation point. I have seen other minds come, develop, and keep on doing so, never stopping the process, always seeking, learning.

All this is as a parade. Some marchers falter, drop out, muddle into sidelines; the balance move on. The farther the

parade moves, the fewer they become. To ask any why they falter and step out, and why others keep on, is to understand that every person lives physically and thinks mentally within the subluxation range of his mental impulse quantity ability to keep on keeping on. In ratio as they mentally and physically live below par, they don't know. In ratio as they live above par, they understand. He who physically falters develops an adroit series of mental alibies beyond the ken of healthy reason. He who physically grows, develops reasoning value that keeps on pushing back his horizons.

With a movement growing as rapidly as Chiropractic, with little known and much to be revealed, it would be surprising did we not have each type in our ranks. Let me talk to a practicing Chiropractor, and I'll date his subluxation and its physical and mental interference that produced his standing-still year. Chiropractic was born in 1895. IT has been and is growing. We have Chiropractors who came to school with a subluxation and never took an adjustment. Others got a concussion while here and never had it corrected. Others got jars and jolts after leaving and still carry effects. The subluxated interference slows down energy-flow with which he can think, which limits brain capacity. Without adjustments, they are sick in brain as well as body. The line is narrow between. To be adjusted is to secure more power for both brain and body.

I have frequently said: "The average Chiropractor is as sick as the average patient who enters his office, and he needs adjustments as much as the patient."

In a work of this magnitude, encompassing many phases of thot and angles of research to ascertain facts, it is not within the province of one man to secure all evidence, ideas, or conclusions upon which subject matter is based. I extend special credit to W. L. Heath, D.C., A. B. Hender, M.D., D.C., C. Q. Cadman, D.C., Herbert Hender, D.C., H. C. Chance, D.C., A. A. Wernsing, D.C., and Wm. P. Brownell, D.C., for valuable aid, counsel, and suggestions. Each of these, in his department, has aided its production. Each has threshed its fundamentals for hours until we could accept or reject that which was or was not strictly within the realm of an exclusive process of reasoning upon facts to reach deductive conclusions.

Appreciation is here expressed for appreciation shown by students, in the field as well as here in school, who gave steady impetus by acknowledging a need for this work by their kindly consideration in receiving this new education whenever and wherever the Author came their way. During the growth of this work, the Author put on classes at various places. Interest shown, kindly appreciations expressed for its worth, helped more than they can know. Students here in school were compelled to put up with inconveniences while the Author was living and researching, while it was in production. It was these smiles, hopes, and helpful suggestions that made our burden easy.

Living with an Author while writing any book is boresome at its best. I thank my office staff who had to endure the Author while he was giving birth to this new series of evolutionary ideas. Nights, Sundays, or Holidays, always subject to call; they came cheerfully and worked until that bit was finished.

And, most of all, of course, that loving endorsement that always came from Mabel who always understood, smiled, and allowed the Author to rave on until he had whipped out each new idea.

None of these will know what their thotful understanding always meant, because it was such a marked contrast to what we had been receiving just a few years back when the Spinograph and the Neurocalometer were born.

The Chiropractic profession has been divided. One group are convinced that CHIROPRACTIC is an all-complete, all-sufficient philosophy, science, and art, needing no subtraction or addition to its elements; that support but weakens it; that contradictory principles or practices deny its objective. The other group believe that additional subjects, altho medical in principle and practice, help a Chiropractor to render a more all-around practice building value; that "chiropractic" as they understood it is "limited" in its application, etc. Between these groups, there has been no quarter asked or delivered. The Author of this work is the recognized leader of the "straight" group.

(See "SEEKING SPECIFICS", Chapter I.)

The first and only time the legal and lawful rights of this conflicting question have reached a Superior Court, where the merit of both sides of this raging conflict has been tried, where both

sides had their "day in Court" was tried October, 1933, in California. The Author of this work was the leading expert witness for the "straight" side of that issue.

A reprint of that court decision may seem out of place in a work discussing a scientific subject, but when considered that the ultimate objective of this SCIENTIFIC work is the saving of human lives, adding years to life and life to years, and to save those lives it resolves CHIROPRACTORS in the profession to preserve it in its purity for posterity, it will be conceded that the LAWFUL protection of this work is an invaluable integral in its scientific protection, once scientific progress has been made.

With this explanation, we offer no apology to readers for placing this evidence before you.

Chiropractic "Teaching MUST BE of The Art or Science Itself—Which MUST BE Chiropractic"—Says Judge James in California

No. 43645

Filed Jan. 16, 1934.

HENRY A. PFISTER, Clerk
By Albert J. Newlin, Deputy

**IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA,
IN AND FOR THE COUNTY OF SANTA CLARA.**

No. 43645

THE PEOPLE OF THE STATE OF CALIFORNIA ON THE RELATION OF THE CHIROPRACTIC LEAGUE OF CALIFORNIA, a Voluntary Association,
Plaintiff and Cross-Complainant,

vs.

ROSCOE C. STEELE and LOIS B. STEELE,
partners doing business under the style of
DRS. STEELE & STEELE,

Defendants,

vs.

GLEN SIPES and J. K. CHRISTIE, and ASSOCIATED CHIROPRACTORS OF CALIFORNIA, a Voluntary Association,
Intervenors and Cross-defendants.

MEMORANDUM OF OPINION

This cause is prosecuted by the State of California, through the Attorney General, TO ENJOIN THE PRACTICE OF CER-

TAIN HEALING METHODS IN TREATING THE PHYSICAL AILMENTS OF HUMAN BEINGS WITHIN THE STATE. It was originally brought against the defendants, Roscoe C. Steele and Lois B. Steele; but through subsequent pleadings, similar charges are brought against interveners and cross-defendants, Glen J. Sipes and J. K. Christie, and these latter will be referred to hereafter, in company with Steele and Steele, as defendants.

The issues, both of law and of fact, **ARE FEW AND QUITE DEFINITE.**

The defendants have certificates issued to them to practice the healing art, under the Chiropractic Act, **AND THEREBY LICENSED TO PRACTICE CHIROPRACTIC, AND NOT OTHERWISE.** They hold no other license to practice any healing art in California.

They are practicing, and are advertising and holding themselves out to the public as practicing, certain modes of treating the sick or afflicted, termed ophthalmology, nasal therapy, otology, intestinal flushing, pharyngology, laryngology, genito-urinary therapy, proctology, irridiagnosis, scientific colon hygiene, sinusoidal current, **ELECTRONICS**, diathermy or artificial fever, d'arsonval auto condensation, cold quartz, ultra violet light, galvanic current **AND DIET.**

These modalities, the defendants claim they are entitled to practice under their certificates issued them by the State, licensing them to "practice Chiropractic." If this be so, the case of the State must fail; **AND HENCE WE ARE PRIMARILY CONCERNED HERE WITH THE PROPER CONSTRUCTION TO BE GIVEN THE ACT UNDER WHICH THEIR LICENSES ARE ISSUED.**

Some procedural objections have been raised in the case, of which we will first dispose, before undertaking the solution of the main problem.

The right of the State to regulate the practice of healing arts is conceded. For the proper and practical exercise of this function, it is obviously necessary to set some standards of learning and skill, which should be the qualifications of persons practicing these arts. And to such persons as are shown to possess these qualifications, the State may issue permits or licenses to so practice; at the same time, **AND AS A NECESSARY PROTECTIVE MEASURE, FORBID SUCH PRACTICE BY PERSONS NOT SO LICENSED.** As long as these regulations are uniform in their application, they are proper, and will be upheld.

Of course, it is conceivable that a strict application of such regulations might exclude from practice, persons possessing even a greater degree of skill and learning than is necessary to meet the requirements, but who have not obtained such licenses. The

answer to such an objection, however, is apparent on the face of it. IF SUCH PERSONS ACTUALLY POSSESS SUCH DEEP LEARNING AND SKILL, IT SHOULD BE AN EASY MATTER TO ESTABLISH THE FACT, AND OBTAIN THE REQUIRED LICENSE BY COMPLYING WITH THE ESTABLISHED REGULATIONS.

Laws regulating the practice of the healing arts are of the highest importance to the public welfare. They are enacted in the necessary protection of the health and lives of the people. The sick and the suffering are credulous of promises to cure; and few have the ability, if they have the inclination, to determine for themselves, the qualifications of the practitioner. In the enactment and strict enforcement of these salutary regulations, the people have their measure of safety and protection from ignorance or worse. Without such, they would be the prey of charlatans and quacks.

It would be difficult to conceive of anything more directly affecting the public health, or the comfortable enjoyment of life, than these laws.

And equally certain is it, that the violation of them is injurious to public health and interferes with the comfortable enjoyment of life.

These considerations bring the matter within the legal definition of a nuisance. And, as the practice of the healing art, in violation of the regulatory statutes would affect a considerable number of people, or even an entire community or neighborhood, IT WOULD CONSTITUTE, IN LAW, A PUBLIC NUISANCE.

That the commission of a public nuisance may be enjoined is well settled. Nor does the fact that the act constituting the same is punishable as a crime deprive the State of the right to the more sweeping and effective remedy in equity.

IT IS, THEREFORE, MY OPINION THAT THE FACTS HEREIN PLEADED WILL JUSTIFY THE RELIEF SOUGHT.

Having disposed of the preliminary objection having to do with the remedy herein sought, the principal issue of the case will be considered.

It is unlawful for any one in this State to practice, or attempt to practice, or to advertise or hold himself out as practicing, any system or mode of treating the sick or afflicted, OR TO DIAGNOSE, treat, operate for, or prescribe for, any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition of any person, WITHOUT HAVING, AT THE TIME OF SO DOING, A VALID, UNREVOKED LICENSE SO TO DO.

There are various forms of such licenses provided for, under several statutes; AND EACH OF THESE LICENSES OR CER-

TIFICATES CONFERS UPON THE LAWFUL HOLDER THEREOF THE RIGHT TO PRACTICE SUCH HEALING ART, BY THE METHOD, AND TO THE EXTENT, ONLY, AS PRESCRIBED BY THE ACT UNDER WHICH IT IS AUTHORIZED. IT IS A GRANT—NOT A LIMITATION. ITS RIGHTS CONFERRED ARE MEASURED BY WHAT IT EXPRESSLY PERMITS, AND NOT BY WHAT IT FAILS TO FORBID.

The defendants, as heretofore stated, hold only certificates or licenses, issued under the Chiropractic Act; and the enabling part of that Act is contained in Section 7 thereof, reading as follows:

"17. Certificate to practice. One form of certificate shall be issued by the board of Chiropractic examiners; which said certificate shall be designated 'License TO PRACTICE CHIROPRACTIC,' which license shall authorize the holder thereof, TO PRACTICE CHIROPRACTIC in the State of California as taught in CHIROPRACTIC schools and colleges; and also to use all necessary mechanical and hygienic and sanitary measures incident to the care of the body, but shall not authorize the practice of medicine, surgery, osteopathy, dentistry, or optometry, nor the use of any drug or medicine now or hereafter included in materia medica."

On a reading of this section, with respect to its application to the case at bar, two questions at once present themselves for solution before a proper conclusion herein can be reached.

1st. What is meant by the use, in the statute, of the term "Chiropractic"?

2nd. How much additional license, if any, is conferred by the clause, "and, also, to use all necessary mechanical, and hygienic and sanitary measure incident to the care of the body"?

With regard to the first question:

The word "Chiropractic" is a modern, fabricated word apparently from two Greek derivatives; and may be freely translated as "manipulation by hand." IT WAS APPLIED TO THE SYSTEM OF HEALING, CONCEIVED AND DEVELOPED BY DR. PALMER, ABOUT FORTY YEARS AGO. HE PRACTICED AND TAUGHT THE SYSTEM — FOUNDING A SCHOOL THEREFOR, WHICH WAS THE ORIGINAL AND CENTRAL SOURCE OF CHIROPRACTIC THEORY AND PRACTICE, AND WHICH IS STILL FUNCTIONING AS THE PARENT SCHOOL OF CHIROPRACTIC.

Dr. Palmer defined Chiropractic as "... a system of adjusting the segments of the spinal column by hand only, for the correction of the cause of disease."

Another (Palmer) definition is as follows: "Chiropractic is the science of palpating and adjusting the articulations of the human spinal column only."

A third and more comprehensive definition which is found in Dorland's (Medical) Dictionary is "A system of adjustment consisting of palpation of the spinal column to ascertain vertebral subluxations followed by the adjustment of them by hand, in order to relieve pressure upon nerves at the intervertebral foramina, so that the nerve forces may flow freely from the brain to the rest of the body." (Another Palmer definition)

Without attempting to unduly prolong a discussion of the essential character of Chiropractic theory, it may be stated, generally, that the science or art of Chiropractic is found in these general propositions: that in the brain of the human animal is the point of control of an innate intelligence which sends its controlling forces by way of the spinal cord through the spinal column and then through the various nerve trunks emitting from the spinal cord and passing through the intervertebral foramina to nerve branches ramifying to all parts of the body, through the perfect functioning of which, health is maintained, but through interference with the transmission of those innate forces through or over the nerve, disease is produced; that owing to the spinal column being the only segmented structure of bone through which these nerve trunks pass and the possibility of displacement of its segments changing the size and shape of the intervertebral foramina, subluxations occur and there offer interference with the transmission of innate forces directly or indirectly: that all disease is thus traceable to impingements of nerve tissue in the spinal column. Chiropractic claims the knowledge of this all inclusive cause of disease and the ability to adjust and correct these displacements of the segments of the spinal column, thereby removing interference with the transmission of the innate forces. It claims that such adjustment does not add any material forces to the body, but allows the innate to restore to normal what it would have had, had there been no interference. In this manner, it is claimed, health is restored.

IT WILL THUS BE OBSERVED THAT THE THEORY, SCIENCE OR ART OF CHIROPRACTIC IS QUITE DEFINITELY CIRCUMSCRIBED IN ITS CHARACTER, SCOPE AND PRACTICE.

On the trial of this case, it appeared that there were two groups or schools of Chiropractic, which were generally referred to as "The Palmer Schools" and "The Mixing Schools"—these latter schools teaching the practice of the modalities, or some of them, referred to in the pleadings here, and the practice of which it is sought to enjoin in this action. It is claimed on the part of the defendants that, because the licenses or certificates of the defendants entitle them to "practice Chiropractic as taught in the Chiropractic Schools or Colleges" and such modali-

ties are, in fact, taught in these latter schools or colleges, that they are thereby licensed to practice such modalities. WITH THIS CONTENTION THE COURT IS NOT IN ACCORD. It is not alone the fact that the healing art which it is undertaken to practice is taught in such schools or colleges that entitles the licentiate to practice the same; BUT ALSO THAT IT IS, FUNDAMENTALLY OR ESSENTIALLY, CHIROPRACTIC. The teaching of music may be carried on in a Chiropractic school, but that would not make music part of the art or science of Chiropractic. THERE IS NO LIMITATION UPON WHAT MAY BE TAUGHT IN SUCH SCHOOLS; but, in order to render teaching of such schools the basis of the licentiate's practice, SUCH TEACHING MUST BE OF THE ART OR SCIENCE ITSELF—WHICH MUST BE CHIROPRACTIC. BY NO STRETCH OF THE IMAGINATION, IN THE COURT'S VIEW, CAN THE PRACTICE OF THESE VARIOUS MODALITIES COMPLAINED OF BE BROUGHT WITHIN ANY REASONABLE CONSTRUCTION OR DEFINITION OF CHIROPRACTIC. If their use is justified at all by the defendants, it must be justified solely upon the theory that the practice of the same is permitted by the clause "... and, also, to use all necessary mechanical and hygienic and sanitary measures incident to the care of the body. ..."

It is the contention of the defendants that these various modalities may properly be practiced by one with a Chiropractic certificate as being necessary mechanical and hygienic and sanitary measures incident to the care of the body.

An examination of the character of these several modalities would seem to quite effectually answer this contention.

Diathermy, sinusoidal current, d'arsonval autocondensation are all therapies in which various forms of electrical currents are applied to the human body for various purposes—all of them possessing elements of grave danger when applied unskillfully—AND ALL OF THEM BEING AS FAR REMOVED FROM THE BROADEST POSSIBLE CONCEPT OF CHIROPRACTIC.

In the practice of the modalities of proctology and so-called scientific colon hygiene, the practitioner inserts into the body, through the rectum, instruments and other substances up the descending colon through the transverse colon and down the ascending colon as far as the caecum, traversing practically the length and breadth of the interior of the lower abdomen. BY NO STRETCH OF THE REASON CAN IT BE SAID THAT THIS IS A NECESSARY HYGIENIC OR SANITARY MEASURE INCIDENT TO THE CARE OF THE BODY.

Nor can the Court view the use of cold quartz or ultra-violet

ray as a hygienic or sanitary measure or a mechanical measure incident to the care of the body.

Genito-urinary therapy includes treatment of all of the genitals and urinary parts of the body, and in these parts are the bladder, prostate gland and the kidneys; and the treatment of which involves the insertion into these parts of instruments, or other materials, and this, it is claimed, is a necessary mechanical hygienic or sanitary measure incident to the care of the body. TO STATE THE PROPOSITION IS AT ONCE TO REFUTE IT.

The practice of ophthalmology, or treatment of the eyes, nasal therapy, or treatment of the nose, otology, or treatment of the ears, pharyngology, or treatment of the pharynx, and laryngology, or treatment of the larynx, are all special therapies which are ordinarily committed even by those practicing under the all inclusive physician's and surgeons' certificate to specialists, and can, in the Court's opinion, IN NO MANNER BE BROUGHT WITHIN THE CLAUSE OF SECTION 7 OF THE CHIROPRACTIC ACT NOW UNDER CONSIDERATION; AND ARE CERTAINLY FAR REMOVED FROM ANY KNOWN DEFINITION OF CHIROPRACTIC.

The Court does not intend to, nor does it, express any opinion as to whether the defendants, or other Chiropractors of their school, have, or have not, the proper training, knowledge and skill to safely use these modalities in their practice; nor whether they should, or should not, be permitted to do so. With those matters it is not concerned. It is here dealing solely with the state law of California as applicable to persons holding certificates to practice Chiropractic; AND IT IS THE COURT'S OPINION THAT THE PRACTICE OF THE MODALITIES HERE IN QUESTION IS NOT INCLUDED IN THOSE THINGS WHICH MAY BE DONE OR PRACTICED UNDER THE AUTHORITY OR A LICENSE OR CERTIFICATE ISSUED UNDER THE CHIROPRACTIC ACT, AS NOW IN EFFECT.

It follows from the views herein expressed that a decree be rendered for the plaintiff and against the defendants, and each of them, as prayed for, enjoining the defendants from the practice of the modalities in question; and it is accordingly so ordered.

Plaintiff will prepare and submit findings.

WM. F. JAMES, Judge.

THE CALIFORNIA JUDGMENT EXECUTED

**In the Superior Court of the State of California in and for the
County of Santa Clara**

The People of the State of California on the Relation
of the Chiropractic League of California, a voluntary
association,

Plaintiff and
Cross-complainant,

vs.

No. 43645

Roscoe C. Steele and Lois B. Steele, partners doing
business under the style of Drs. Steele & Steele,
Defendants,

vs.

Glen J. Sipes and J. K. Christie, and Associated Chiro-
practors of California, a voluntary association,
Interveners and
Cross-defendants.

ENDORSED and FILED: March 6, 1934.

Henry A. Pfister, Clerk

By E. T. McGehee, Deputy

JUDGMENT

This action came on regularly for trial on the 9th and 10th days of October, 1933; U. S. Webb, Esq., Attorney General, Leon French, Esq., Deputy Attorney General, and Frank V. Kington, Esq., appeared as attorneys for plaintiff and cross-complainant; and Harry G. Henderson, Esq., Edward A. Stuart, Esq., and Homer J. Castellaw, Esq., appeared as attorneys for defendants, interveners and cross-defendants, whereupon evidence was adduced and the matter submitted to the Court for decision and judgment, from which the Court made and filed its findings of fact and conclusions of law;

NOW, THEREFORE, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the above named defendants Roscoe C. Steele and Lois B. Steele be and each of them are hereby permanently enjoined from practicing and/or attempting to practice and/or advertising and/or holding themselves, or each of themselves, out as practicing those certain systems or

modes of treating the sick or afflicted in this State known respectively as irridiagnosis, scientific colon hygiene, sinusoidal current, electronics, diathermy or artificial fever, d'arsonval auto condensation, cold quartz ultra violet light, galvanic current and diet, and from thereby diagnosing, treating, operating for and/or prescribing for ailments, blemishes, deformities, diseases, disfigurements, disorders, injuries and/or other mental and physical condition of persons;

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the above named Glen J. Sipes, intervener and cross-defendant, be and he is hereby permanently enjoined from practicing and/or attempting to practice and/or advertising and/or holding himself out as practicing those certain systems or modes of treating the sick or afflicted in this State known respectively as ophthalmology, nasal therapy, otology, intestinal flushing, pharyngology, laryngology, genito-urinary therapy, proctology and electrotherapy, and from thereby diagnosing, treating, operating for and/or prescribing for ailments, blemishes, deformities, diseases, disfigurements, disorders, injuries and/or other mental and physical condition of persons, and from using in his practice the letters "E.T." as a suffix to his name;

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the above named J. K. Christie, intervener and cross-defendant, be and he is hereby permanently enjoined from practicing and/or attempting to practice and/or advertising and/or holding himself out as practicing those certain systems or modes of treating the sick or afflicted in this State known respectively as electrotherapy, radionics and radio therapy, and from thereby diagnosing, treating, operating for and/or prescribing for ailments, blemishes, deformities, diseases, disfigurements, disorders, injuries and/or other mental and physical condition of persons.

Let plaintiff have judgment for its costs.

WM. F. JAMES, Judge

Dated: March 6, 1934.

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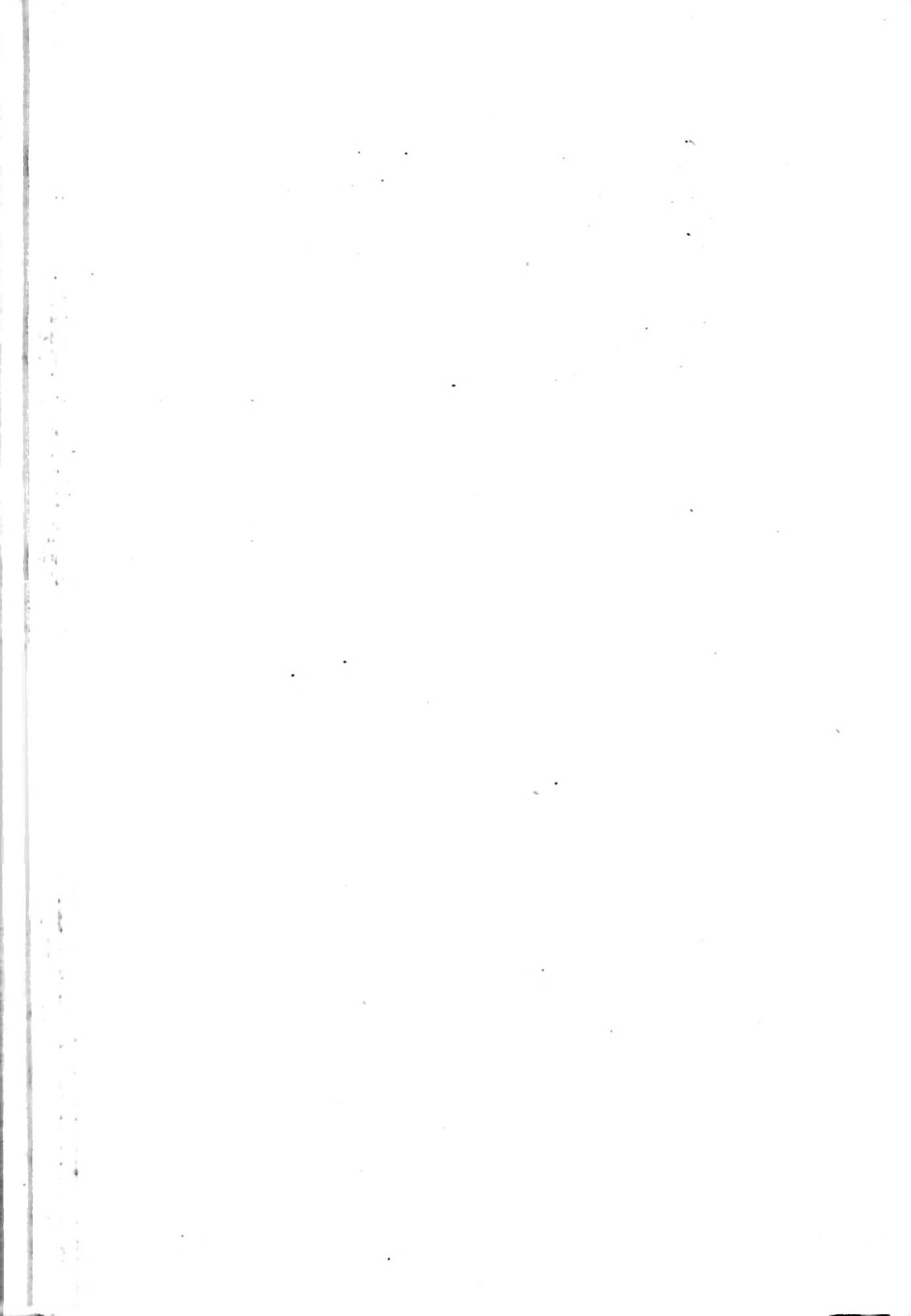
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Foreword



THE business world lives, thrives, grows, and expands on seeking specifics. Commerce, transportation, finance, sciences, and professions — always seek ultimate objective specifics. To strive to attain specifics IS progress. There is a progress in friction, in striving to produce a material economy in things and conditions. There is also a very unjust appraisal often bestowed on scientific development which seems to the criticizing spirit to be useless. It is expressed in: "What's the use?"

Early last century it was discovered that a magnetized needle, poised upon a pointed support at its center, so as to be free to rotate in a horizontal plane, would be affected and caused to turn on its support, if a wire carrying a current of electricity were brot near it and more or less in parallel with it. This seems a very insignificant fact, but it showed the action of force through space and the scientific world of those days was enlightened enough to realize the wonder of it. What was the use of such trivial experiments?

Fortunately, students of this budding science did not think about the usefulness of following up experiments of Faraday and Ampere. They were utterly trivial in what they did, and in what they showed; but what they were to lead up to and what were the developments impending in the next eight or ten decades, were far from trivial. What seemed a silly plaything to the practical utilitarian minds, has completely revolutionized human industry. Fortunately all minds were not utilitarian. Progress went on in spite of the discouraging attitude we speak of. Changes that followed during last seventy-five years exceed progress of preceding centuries of reign of man-kind.

By "ultimate objective specifics" is meant: "ultimate" something away ahead, seemingly beyond reach — the head of the stairs reached, only to find it the beginning of another flight; "objective" meaning to set a peg, establish a pace and try to attain that which is a definite thing; "specifics" meaning to set a far-visioned exact working approximate principle not in exist-

ence, something quite beyond present-day reach, and then stretch out tomorrow and get it.

Thomas A. Edison sought specifics. Passing thru the Smithsonian Institution, Electrical Department, I saw hundreds of globes accredited to Mr. Edison. Why so many? Thousands of elements were tested, tried, and thrown away. Each element tried gave light. He sought a specific that would attain MORE LIGHT with LESS ELECTRICITY. Each succeeded in its way and time, but none attained the greatest efficiency in reaching that ultimate goal. Insofar as they GAVE more light, they succeeded. Insofar as some burned MORE electricity and gave LESS light than others, they failed to reach HIS ultimate objective specific.

See Mr. Edison in his laboratories. Thousands of wires, different metals, different sizes, different chemical compositions tested; some succeeding more, others less. Thousands of fibres of various vegetable and growing strings were secured, tried, and tested; some succeeding more, others less — ALL GIVING LIGHT. He was always seeking THAT ONE combination of conditions which would resist transmission greatest, with least consumption of electricity, which would give greatest white heat, to radiate greatest white light; to consume LESS electricity, to perform MORE work, to radiate MORE light.

Finally came the vacuum tube and tungsten wire. TODAY the Mazda globe gives MORE LIGHT and has materially reduced the consumption of electricity. Contrast carbon globe with little light, much electricity, great cost, with tungsten vacuum globe with much light, little electricity, little cost. There has been a great advance in economy of light production. The candle lamp and batswing and fish-tail gas burners were supplanted by incandescent Welsbach burner of greatly increased economy. In electric lighting, carbon filament was replaced by tungsten filament of THREE-FOLD its economy. The modern electric light with tungsten wire filament is nearly four times as efficient as carbon filament lamp was. Mr. Edison could have stopped any time, any place. He HAD produced LIGHT. He was NOT content TO STOP. He was content ONLY as he created MORE light with LESS electricity. In ratio as he produced

MORE light, he USED less electricity; and as he used LESS electricity, he created MORE light.

Was Mr. Edison interested in blowing glass bubbles? Was he interested in making money? WHY did he keep on experimenting, testing, trying different materials, never fully satisfied? If he had been interested IN CREATING LIGHT IN A GLASS GLOBE, he could have stopped years before. Was LIGHT the ONLY objective? He had IN MIND an ultimate objective and he wanted it to live IN REALITY, thru the globe. The ULTIMATE goal—if there be an ultimate—was cold light akin to the fire-fly or glow-worm. Men had so far attained only heat-light, building up resistance to greatest heat, white in color, which is light as a by-product.

Is Henry Ford interested in building cars; seeing how many he could sell? Is he interested in making and amassing money? Is he concerned in earning money or in using money to some other end?

Let me quote Mr. Ford:

"I don't know how many cars Chevrolet sold last year. I don't know how many they're selling this year. I don't know how many they may sell next year. AND—I DON'T CARE."

So last month, said Henry Ford, sitting cross-legged in the shadow between two windows and looking across Mr. William J. Cameron's glass-walled office in the immaculate Ford Engineering Laboratory. Since Mr. Ford is now completing the third consecutive year of a bitter competitive struggle—during which he has consistently been on the losing end—his indifference to competition appears incredible. But it does exist, and its existence is thoroughly genuine. To Mr. Ford there is only one automobile, there has always been only one automobile, and there will always be only one automobile. His sales have been declining, his deficits have been appalling, he has fallen so far behind the Chevrolet that he has almost been caught by the oncoming Plymouth. But he remains indifferent.

Once, at one of the round-table lunchroom conferences where Mr. Ford daily meets his hired men, the conversation did turn to Chevrolet and Plymouth progress. Particularly worried were the manufacturing executives who run his gigantic River Rouge

works. Finally Mr. Ford spoke up. "Yes," he said, "I guess the Chevrolet people have accomplished what they set out to do all right."

"How do you mean?" asked one of them.

"Well," said Mr. Ford, "those fellows are trying to get you fellows' minds off your work. And they seem to have succeeded mighty well." There were no more discussions of Plymouth and Chevrolet.

The truth of his aggressive disinterest in competitors' statistics is that MR. FORD THINKS IN TERMS OF AN AUTOMOBILE. He thinks more in terms of A SINGLE automobile than he thinks in terms of producing that automobile in units of a million per annum. (Except that when he is experimenting with one automobile part he is careful to make that part so simple that it can readily be standardized.) But it is doubtful whether Mr. Ford ever thought to himself, "I will make a million automobiles a year." What he thought was, "I will make—within certain cost limitation—THE PERFECT automobile. AS A RESULT OF ITS PERFECTION, MAYBE A MILLION PEOPLE A YEAR WILL WANT COPIES OF IT. Which I will be happy to let them have."

Henry Ford sought specifics. Glance your eye over the Ford car models as they developed down thru the years. Why so many? Didn't each of them run? If Ford was interested in building an automobile that WOULD run, he could have stopped when he finished the first one THAT RAN. Ford was interested in something deeper than a machine that would run on four wheels. He sought a specific that would attain A BETTER CAR for LESS DOLLARS. Thousands of elements were tried, tested, and thrown away. Each was an expensive experiment. Each succeeded within its time and way. Why throw them away; why discard them in the junk yard? Each car RAN—what more was demanded? Why didn't he quit; sit back satisfied, content to let the world of transportation be in peace within its commercial soul? Why keep them eternally stirred up? Why struggle within himself and keep everybody else unsettled? Each failed to reach HIS ultimate objective specific.

See Mr. Ford in his laboratories. Thousands of experiments developing breakable glass to non-shatterable wind-shields in his

glass factory. How to finish leather to increase wearing qualities; to produce lighter metal that would not rust, tarnish, or stain; cylinders that would resist more wear than before; flexible springs to increase ease of riding; paints that would keep their finish longer. The wheel base has been lowered and widened, bodies have been greatly strengthened; he created better lighting systems, reliable brakes, dependable steering apparatus, trustworthy tires, etc. Thousands of experiments, covering years, fearfully expensive; thousands of them failing—finally to succeed with ONE that worked in each division of that car. Discouraging numbers of failures—and finally to emerge with THE ultimate objective specific, which when assembled in the whole, made the GREATEST CAR made CHEAPER and LAST LONGER.

Was Mr. Ford interested in playing with chemicals, walking thru his buildings, pleased with them and how many employees he could hire and fire? Why did he keep on keeping on experimenting, directing year after year—never satisfied? He had IN MIND that ultimate objective specific and he could not stop until it lived IN REALITY in the car.

Many a time he must have been importuned to sit down, lie back, and rest serene in his work. Many a time he must have been damned by his department heads because he would not stand still and be satisfied. Every other manufacturer of automobiles has cursed him for driving them to duplicate his original conditions. Ford had the happy (?) faculty of keeping the entire industry upset, stirred up, riled, unsettled, worried. He drove himself; he drove his organization, as well as competitors and contemporaries. If he had stood still, they would have called him blessed.

Then came the aeroplane—heavy clumsy, slow, cumbersome, made of wood and cloth, combustible, breakable, landing like an ox. It weighed too much for its horse-power; its weight hindered its speed.

ALL aeroplane builders were working to a specific—to make them lighter, per horse-power, to produce more speed, to make them safer for transportation.

Mr. Ford stepped into this picture and built an all-metal plane

that couldn't burn; which withstood storms; would land with comparative safety; made travel a luxury and pleasure. To do this, Mr. Ford developed a new, very light metal, duralumin.

Experiments have been conducted for years to DECREASE weight, to INCREASE horse-power, to INCREASE speed, to INCREASE safety factors—always that fight thru years to reach an ultimate objective specific.

WHY did manufacturers of aeroplanes keep on struggling, striving to outvie each other? Weren't they FLYING? If FLYING was the last word, they HAD arrived. They could sit back and rest on their laurels.

Every manufacturer of planes kept each other on the anxious seat. Each kept others worried. If they could get together, agree, have harmony in factories, they could stop this ceaseless warfare, striving to outdo each other. They could shake hands and be commercial friends, rather than commercial rivals.

Over and above aeroplane manufacturers, as was true of Edison and Ford, there is a Destiny that shapes men's souls. No man is Captain of his Inner Self. It is THAT which fore-ordains man's work, that drives him on, that plants ULTIMATE OBJECTIVE SPECIFIC goals, which no man can stop, once his feet are planted on the road to achievement. Some men turn their face against Destiny, but they cannot stop Destiny coming thru some other man. Man can work WITH, but he cannot deny DESTINY its hearing and accomplishment when time arrives for its plans being made practical.

Somebody in the sickness field would devote his study, observation, and research to SEEKING A SPECIFIC FOR THE CAUSE OF ALL DIS-EASE. It WAS in the abstract. Why not make it real?

Didn't D. D. Palmer give an adjustment to Harvey Lillard and wasn't his hearing restored? Then was the time for all Chiropractors to sit down and be content. There was the principle and practice. It worked! What more could anyone demand? Thousands of ideas came, went, were substituted in subsequent years, time and again. Our people and their work were in flux; nothing finally settled; all in turmoil; few followed the parade; many were content to sit and wait "until it was finished", little realizing that nothing is EVER completed.

Until 1922, our profession was building a structure based upon beliefs and faiths in principles advocated by one man principally, who by his dominant methods, held the profession in check in their beliefs and faiths in these beliefs and faiths.

This destroyed theories as theories; hypotheses as hypotheses; beliefs as beliefs; faiths as faiths, and supplanted them with scientific facts which he asked the profession to adopt and accept.

The evolution from theories to facts; from beliefs to knowledge; from a man to an instrument, was upon us.

When electric light came, kerosene lamp business slumped.

When Pullman came, covered wagon business slumped.

When automobile came, horse and buggy business slumped.

When facts and knowledge came into Chiropractic, theories, beliefs, and faiths business in Chiropractic slumped.

In ratio as confidence in what instruments proved came in, the value of any man's opinion in Chiropractic slumped.

Scientific facts substituted beliefs and faiths.

Knowledge substituted confidence in A MAN.

Stars were (in theory) demons, until telescopes (in science) proved them other worlds.

World was (in theory) flat, until Galileo suspended his ball and it circled, thus (in science) proving it round.

Chiropractic was a maze of theories, until Spinograph and Neurocalometer scientifically proved new truths.

For years, Chiropractic was founded on beliefs and faiths in theories and hypotheses.

NOW it is builded on scientific data which man can secure for himself.

Even as a boy, in the very youth of my life and Chiropractic, I made a vow:

THAT I WOULD LIVE TO SO DEVELOP CHIROPRACTIC THAT IT WOULD FIND AND LOCATE AND BE ABLE TO CORRECT A SPECIFIC CAUSE FOR EVERY DIS-EASE IN THE HUMAN BODY; AND TO SO DEVELOP THIS PHILOSOPHY AND ART THAT IT WOULD BE MADE SCIENTIFIC, WHERE IT WOULD BE RECOGNIZED AS SCIENTIFIC BY SCIENTIFIC MEN, AND SO PROVED BY THE USE OF SCIENTIFIC INSTRUMENTS.

In 1923, our professional family was at peace within itself. All were satisfied, happy, contented. The machinery was well oiled and a steady income was assured. Every man was a friend to his neighbor. Sitting in the saddle was DESTINY who convinced ONE MAN that the final word had not been spoken; that there were secrets concealed in that spinal column which we needed to know; that HE was THE man to dig them out, reveal them, and give them to the sick and suffering world. That ONE MAN began digging. He discovered hidden human golden nuggets. He also discovered that mankind resents being awakened from day-dreams; fights when rudely awakened; prefers ancient failure play-toys to new successful inventions. He further discovered that mankind is jealous of peace and comforts and refuses to be budged to grow to keep pace with a growing world of truth.

Commerce, science, transportation — electricity, automobiles, aeroplanes, trains and what have you—business in every form is always in all ways reaching greater specifics from year to year. We anticipate and expect such and would be surprised if it didn't. Development is the trend of the times.

In professions our state of mind anticipates the opposite. We expect them to stand still. Law is based on dead precedent. Ministers preach same gospel, same way it used to be. Principles and practices of medicine grope from one style to another within the same old fads.

Should we be surprised to find human resentment when the public learns of ONE new profession that DARES to build a NEW principle and practice and attain a NEW result? Should we be surprised when the public looks askance when Chiropractic gets in tune with commerce, science, and takes on progressive attributes of other commercial enterprises? Should we be surprised when some Chiropractors prefer to lapse backward and remain quiescent as other professions have done?

DESTINY waits for no man. He rides to the pace She sets, or is lost in oblivion when the day of reckoning comes.

SEEKING SPECIFICS has ever been a burning ambition. This book is the result of that seeking!

CHAPTER I

SEEKING SPECIFICS



SPECIFIC (Stedman) "A remedy having a definite curative action in relation to a particular disease or symptom, as quinine in relation to malaria, or mercury to syphilis. Four, in eclectic practice denoting a class of drugs preparations of standard strength designed to meet certain special indications in the treatment of diseases or symptoms."

Specific (Dunglison) "Remedial agent to which is attributed the special property of removing some particular disease; examples are mercury in syphilis and quinine in malaria."

Specific (Webster) "4. Med. Exerting a peculiar influence over any part of the body; preventing or curing disease by a peculiar adaptation; as quinine is a specific medicine in malaria."

Specific (Palmer) "The Law of Innate is specific — it never varies hence is constant, fixed, permanent.

"A specific is something which, if always applied in the same way, same quantity to exact like conditions, will get the same results—by permitting the law to act.

"Dis-ease is not law—it is a contrary. It is never fixed, is fluctuating hour by hour, case by case."

For 5,000 years the medical profession have been consistently seeking A SPECIFIC FOR THE CURE OF ALL DISEASES. First one way, then another, they have woven off and on the stage of human effort—always to the same end. Millions of dollars; millions of bodies have been dissected—both human and animal, dead and alive. Laboratories of all kinds have been used. Libraries have been written, revised, and discarded. Today they have 148 "specific serums" for 148 "specific diseases" as a net result. Those will be thrown into discard, given a few years.

For 5,000 years that profession has run the race down thru blood diseases and blood remedies to purify the blood; nerve exhaustion with nerve tonics; serum specifics for germ diseases. They have long sought that elixir that could eradicate diseases from the human race, that they might step-up the efficiency of that race; that they might think more clearly; function more

normally. They have run the gauntlet from removing appendices to tonsils; now they extract teeth because they "create a toxin in the body necessitating an anti-toxin." They have pursued fashion after fashion, fad after fad, style after style, generation after generation; never arriving at a "specific" for the CURE of any disease.

The answer of the failure is simple. No person or group of persons, no matter how they work, ever can or ever will locate a specific for CURE of any disease. Disease is AN EFFECT. No cure can EVER be found for CURE OF ANY EFFECT. So long as effect IS effect, it has a CAUSE. To call one effect a cause of another effect, is to play the vicious circle of the dog chasing his tail. To ignore a CAUSE remote and DIFFERENT FROM effect by seeking a SPECIFIC CURE FOR EFFECT is fundamentally unsound. It is appalling when we realize that humanity has suffered 5,000 years while the medical profession has been chasing itself around a vicious circle, wasting valuable research on a wrong fundamental.

Medical men sought a specific for THE CURE of disease. Chiropractic sought a specific CAUSE of disease. Medical men assert they too sought a SPECIFIC CAUSE. This is and is not so. The medical cause and effect were not related and were frequently antipodal to each other.

Medical men say "high blood pressure"

"germs"

"environment"

"heredity"

"contagion and infection"

"wrong diet"

"poisons in the system"

"unbalanced chemistry"

"drinking water contained poisons"

"milk contained tuberculosis germs"

"pork contained trichina"

"impure blood"

and many others were SPECIFIC CAUSES of many diseases.

They sought SPECIFIC CURES for reducing high blood pressure, killing germs, to modify environment; cure disease in the

living, in spite cause of heredity in dead; disinfect contagion and infection; change diet; purify drinking water; sterilize milk; inspect meats, vegetables, and foods with Pure Food Acts, anti-toxin serums, etc.

Diseases are classified as constitutional

- cardiac
- respiratory
- febrile
- mental
- genito-urinary
- unknown origin
- nervous
- secretions and excretions
- eye, ear, nose, and throat
- sexual

While each is thus classified, each local organic condition has a general effect on the balance of the body; and the balance of the body has an effect on each local organic condition. It is impossible to distinctly set forth any individuality of independence of any from all the rest.

The majority of their SPECIFIC CAUSES were far removed from the character of their SPECIFIC CURES. If germs were removed from things natural, external to man, all life would cease. The moment we enter man, all natural and rational reasoning ceases. Medical men substitute "medical science." Germs become A CAUSE of everything dead, in man. Germ life in milk must be killed. We pasteurize milk. "Germs IN MAN must be killed for they kill man." There is no inter-relationship between germs and killing germs to CURE disease.

In seeking a specific for "the medical cause" of disease, the approach was on THE THEORY that "cause" was EXTERNAL to man (as evidenced by germs, environment, heredity, etc.). In seeking a specific for THE CURE of disease, medical approach was on the THEORY that inasmuch as CAUSE was EXTERNAL to man, so would be the cure (as evidenced by salves, drugs, prescriptions, diet, etc.).

In seeking a specific for THE CHIROPRACTIC CAUSE of all dis-ease, the approach was on THE OBVIOUS FACT that THE

CAUSE AND CURE were INTERNAL to man; therefore the absence of any and all alibies, or external applications, injections, etc., reliance being placed upon Innate Intelligence — which is within.

Outside germs, environment, heredity, etc.; outside salves, drugs, prescriptions, diet, etc., and Innate Intelligence from within without, mark the distinctive difference between failure and success, sickness growing worse, and health growing stronger, death and life.

In absence of knowledge, the human mind offers substitutes. In absence of ability, the human mind offers alibies. In absence of facts, the human mind manufactures denials.

The medical profession have never found THE cause of ANY disease, hence have never been able to CURE disease. Germs, inheritancy, environment are offered as substitutes. Failures to get sick well, create a void necessity for treating effects, prescribing drugs as reasonably safe alibies for failure. With no understanding of Innate Intelligence within, they manufacture its denial and substitute "sympathy" and reflex action as unreliable unsatisfactory explanations that do not explain function.

In presence of knowledge of specific cause of all dis-ease, the Chiropractor finds no necessity to substitute, alibi, or manufacture denial. His reasoning is affirmative and positive. With presence of ability to adjust cause, sick get well. With cause absent, Innate Intelligence becomes present; mental impulse interference is released and restoration occurs.

In days gone by, when the Chiropractor did not know THE specific cause of all dis-ease, he too substituted 22 vertebrae. When he had no ability to locate accurately THE cause, our group-mind alibied with physio-therapies. When we did not know, we stumbled with substitutes for ignorance, alibies for incompetency, and manufactured denials for health.

External "cause" medically is the antithesis of internal "cause" Chiropractically; neither is external "cure" medically the same as internal "cure" Chiropractically.

The worst of these medical CAUSES is that they overlap, interweave, and interlock, and are contradictory to each other, leaving the medical mind seeking A SPECIFIC CAUSE rather than having found one. His mind is in a muddle and quandary

as to which is and isn't; how much of one which is, is to contradict the other which isn't. NO ONE is a SPECIFIC CAUSE in any SPECIFIC sense, therefore no specific cure is possible.

Endless SPECIFIC CURES call for animal, vegetable, and mineral elements; from sky, sea, and earth; from fish oils, animal blood serums, to earth contents; from every country of earth; assembled in countless forms and compositions in chemical equations arbitrarily changing from year to year. No man or set of men can know any reaction of any drug upon any person. It is cut and fit, guess and try, hoping something will do the correct thing. A SPECIFIC—in medicine? It has been sought for centuries. It has NOT arrived!

No principle of CURE is sound, which, in purpose, aims to stimulate or inhibit that which is an effect. Disease IS a stimulated or inhibited function. To stimulate an inhibited effect; or, inhibit a stimulated effect, is to whip up or slow down its opposite; temporarily gaining AN objective; never PERMANENTLY RESTORING stimulation or inhibition to NORMAL quantity level. Stimulation is ABOVE normal quantity level. To paralyze it down to an approximate temporary hypothecated level is to temporarily appease but not to permanently arrive at a NORMAL quantity level. Inhibition is BELOW normal quantity level. To whip it up to an approximate temporary hypothecated level is to temporarily appease but not to permanently arrive at a NORMAL quantity level. Stimulation or inhibition is to relieve, ameliorate but not to cure by restoration. To research on HOW to stimulate or inhibit; WHAT to stimulate or inhibit with; WHICH drug is better or worse to stimulate or inhibit with; whether one drug arrives quicker or slower to functional stimulation or inhibition; to develop newer sedatives or hypnotics; to scheme on what chemicals in combination have greater affinity for certain organs, to more positively or negatively stimulate or inhibit; to know no certain effect of any specific drug, is to play the vicious circle without ultimate gain of permanency of restoration of HEALTH.

In 1895, D. D. Palmer laid down the principle that THE CAUSE OF ALL DIS-EASE was a vertebral subluxation, occluding a lumen thru which nerves passed, producing a pressure upon nerves, causing interference to the transmission of a normal quantity of abstract force generated in the brain and expressed at the

end of the nerve in physiological function. In 1895 a CORRECT fundamental principle was advocated. For 38 years the Chiropractic movement has sought A SPECIFIC FOR THE VERTEBRAL CAUSE OF ALL DIS-EASE. No Chiropractor, from 1895 to date, has added anything to that Chiropractic principle to strengthen it; nobody has subtracted anything from that principle to improve its value. For 38 years the Chiropractic profession has woven back and forth, thru the warp and woof of many techniques, adjustments, moves, systems, etc., to attempt to bring the efficiency of the practice art up to the efficiency of the principle. We have laboriously and scientifically sought to SPECIFICALLY locate that SPECIFIC subluxation which SPECIFICALLY occluded a lumen, which SPECIFICALLY produced pressures upon nerves, at a SPECIFIC place, in a SPECIFIC way, which SPECIFICALLY interfered with transmission of a mental impulse supply, WHICH CAUSED all dis-ease in the human body; which could be adjusted under certain SPECIFIC rules, under certain SPECIFIC methods, and repeat itself SPECIFICALLY, should occasion and conditions necessitate. D. D. Palmer BEGAN working upon a specific THEORY. He lived, hoping that some day he could and would arrive at a definite and positive workable and demonstrable knowledge of that specific art. Gradually the group-mind that followed his teachings included and added until they were "working" upon 26 movable vertebrae. The single specific was lost sight of, altho generally speaking many still stayed within the province of the backbone. Soon 26 vertebrae were adjusted to open all intervertebral lumen. Later we began crawling back to the single specific idea again, with a meric system which systematized the backbone and limited adjustments in number and locations. This developed into "majors and minors," accentuating some, making others less important. Today we confine our study and adjustment to the HOLE (WHOLE) IN ONE adjustment of the atlas-axis region. Today, thru continued use of the exclusive process of deductive reasoning for facts, (elaborated later in this work), we realize the specific has been found in that area between the articulations of occiput, atlas, and axis, wherein is THE cause of ALL dis-ease. The objective, long sought, has been found!

The average student of various healing arts or healing meth-

ods; or those who study various principles of modalities, methods, or modes, seldom grasp the REAL, genuine, and distinctive difference between the fundamental principle of ALL OTHER methods as against the fundamental principle of CHIROPRACTIC. There is a FUNDAMENTAL difference between: seeking a specific for THE CURE of all diseases and, seeking a specific for THE CAUSE of all dis-ease.

To seek ONE medical specific for THE MEDICAL CURE of ALL diseases, rather than seeking A specific for every different disease, as is now trying to be done by the medical profession would require:

- (a) that diseases be accurately diagnosed, if there be such a possibility.
- (b) that diseases be properly catalogued and categorized, as such, that the specifics not get mixed in treatment.
- (c) that diseases be recognized for the differing combinations of effects that they are.
- (d) unreliability of subjective symptoms completely discounted via the practitioners' question and patients' unreliable answer route, as evidenced by ignorance of average case regarding their internal or external conditions.
- (e) that they be studied pathologically, bacteriologically, as well as chemically.
- (f) that these be synchronized harmoniously and not be in conflict with each other.
- (g) diagnostic tests of various and multiple kinds must be uniformly standard, always of equal value, with no false conclusions of fact; to permit accurate proof of constant value, in diagnosis, that treatment be standardized thereby, disease for drug and drug for disease.
- (h) that they be, more or less, recognized as a toxin and their anti-toxin be specifically known.
- (i) that a definite re-action be understood that this may always react and duplicate itself favorably to the welfare of the case.
- (j) empiricism and dogmatism in practice of compounding, and prescribing, as well as physiological action and human

reaction to drugs must be stabilized in treatment of all disease per se, definitely recognized as constants, where accuracy of diagnosing is certain, all guess-work in treatment eliminated thereby.

- (k) that it always works in all cases in same way on same symptoms and pathologies.
- (l) that diseases be recognized as multiple in their multiplying characteristics differing from each other.
- (m) each of which obviously requires a different specific to correspond.

Koch laid down CERTAIN rules which HE held MUST BE complied with TO PROVE that ANY bacterium was THE CAUSE of any PARTICULAR disease:

First: It must be found IN the tissues OR secretions OF the animal HAVING the disease.

Second: THE germ FROM the affected animal MUST BE grown in pure culture on artificial media.

Third: SUCH culture SHOULD produce THE disease when introduced into a HEALTHY animal.

Fourth: The SAME organism MUST BE recovered FROM the tissues OR secretions OF the animal THUS infected.

SEEKING A SPECIFIC FOR THE CAUSE OF ALL DISEASE REQUIRES:

- (a) that disease, per se, can be and should be ignored
- (b) that symptoms, pathologies, diagnoses, histories of effects, etc., could be discounted even tho not denied
- (c) that diagnostic instruments could be tabooed and not used as a wasteful and extravagant use of time
- (d) that dis-ease (notice hyphenation) is simple, not complex; all medical classifications being Chiropractically one common condition, except in degree of energy interference and location.
- (e) that dis-ease was single, not multiple; one thing, not thousands.
- (f) that dis-ease was internal, not external; a lack of energy flow to movable matter, reducing its functional rate of tone, motion, action, or function.

- (g) that life and death were opposites, in presence or absence; no life equals death; death equals no life.
- (h) that dis-ease was an intermediary stage somewhere between total life and total death.
- (i) that CAUSE was a simple, single, internal; not complex, multiple, external; was merely a question of location and character of that which interferes with energy flow.
- (j) that cause was an all-enveloping, all-inclusive for dis-ease, per se; being mechanical and needing correction mechanically.
- (k) that somewhere WITHIN the composite unit was THAT cause and when found CURE would be found within also; neither or none of which could be gathered from the four corners of the earth, compounded and prescribed for consumption.
- (l) there being but ONE dis-ease; there would be but ONE cause; requiring ONE correction; at ONE place; in ONE way; to restore ONE cure, which simplifies the subject of health, its absence and restoration.

The medical profession, as a group-mind, has been sincere, earnest, and honest in supporting its ideal in its search for a specific for THE CURE of all diseases. That it fundamentally assumed a wrong premise and kept on the wrong track and has thereby failed, is not for this moment an issue. That it is sincere, earnest, and honest in supporting its ideal in seeking what it sought is vital, because given a group-mind that IS sincere, earnest, and honest in supporting an ideal in seeking something vital and staying with it for 5,000 years, proves that that very earnestness, sincerity, and honesty will reverse the wrong fundamental to a right one, if the right one is brot forth, demonstrated, and proven right.

The medical profession has had 5,000 years of precedence in establishing its fundamental of general education. They have stamped themselves indelibly in the public mind, as a matter of public service. They have established themselves as sincere, earnest, and honest people, even tho they failed to convince thinking people they are capable of doing what they hoped to be able to do. When the Chiropractic principle and practice

came, in 1895, it met the opposition of established incompetency of medicine, but it also had to battle the sincerity, earnestness, and honesty of a group-mind that was established socially and politically.

It was natural that when the Chiropractic idea was introduced, it would be compelled to draw converts from those who were educated under medical principles and practices, even tho that which drew them from it was because its fundamental was wrong and had failed. Therefore it is not surprising to find the Chiropractic group-mind of today divided into two groups. The minority group understanding, realizing and knowing the full import and importance of what the Chiropractic principle has meant in all its full richness, DIVORCED from all previous medical principles and practices; and, understanding, it has worked intelligently to bring about a stepping-up process of the efficiency of the adjustment art to help develop that specific for the CAUSE of all dis-ease. The majority group not understanding, cannot realize and does not know the full import and importance of what the Chiropractic principle has been at any time in all its rich fullness; therefore attempt TO WED IT to some or all of previous medical principles and practices, during 38 years of its history or that portion of that time it has been in it. They work ignorantly with a correct principle and personify no desire to step-up its efficiency of its adjustment art and thereby do not develop any information or delivery of that specific for THE CAUSE of all dis-ease consistent with its principle. On the reverse, this majority group-mind has stepped back into a realm of medicine and uses medical principles and practices and resents any intrusion in that "right" to continue old systems under a new name. That is the group-mind to which we "straights" apply the title "mixer." This mixer group-mind is only concerned in its "right" to use a new sound Chiropractic principle (because it is a good talking-selling theory) with an old (medical) practice for the purpose of using sick people to make a living off of. (See Superior Court, California, Chiropractic Decision, under Preface, this book.)

There are two kinds of "practitioners" of medicine and surgery: (a) those who, while practicing, seek TO ADD to their store of knowledge, TO INCREASE their competency, to seek

TO FIND that SPECIFIC for the CURE of all diseases. They are truth seekers, interested in facts. They think, study, learn. They use whatever scientific and learned means are at their command. You find them working with men of like objectives. They are of the minority. (b) Those who, while practicing, have no interest in whether medicine grows out of where it is, or not; are more or less satisfied to ease pain, relieve suffering, ameliorate diseases; stimulate some and inhibit others. They follow the path of least resistance; trailing the path made by the first group; practicing what has been established by others and has become commonplace. They are satisfied to make a comfortable living. They garner while the first group sweat from creation. The first group have a step UPward to make. The second group have a standing-still platform. THERE IS NO BACKWARD STEP INTO ANY OTHER PROFESSION THAN THEIR OWN.

The situation in Chiropractic is similar in some respects. We have three kinds of "practitioners": (a) Those who, while practicing, gaining the great vision of desire to achieve; holding a high and lofty respect for their profession and themselves; constantly and consistently supporting an ideal; desiring to increase the value of their human service to the lowly sick, are seeking TO ADD to their store of knowledge; TO INCREASE their competency; realizing that Chiropractic is new, young, is on the right road and has far to travel—this group is seeking TO FIND that SPECIFIC for THE CAUSE of all disease. You find them working with men of like objectives. This type in our ranks is in the minority. (b) Those who, while practicing, have little if any interest in whether Chiropractic lives or dies; whether it is right or wrong; whether it has or has not any ideals inherent within itself worthy of support; whether it accomplishes great objectives or dies in the borning. To them it is an easier method to a richer living and as long as they can keep patients coming, it is a good thing; if they stop coming, then there was little to it anyway. They follow the path of least resistance; let others assume burdens of discovery and development; condemn because they don't understand what it is all about; will not investigate to find out. If others use something new, they will follow some day when it is inevitable. They are satisfied to make a more comfortable living in Chiropractic than

at some "job." While others chopped down the virgin forest, they are satisfied to till a bit of the soil. (c) This group, knowing and caring even less than the second, cannot even stand still. They slip and keep slipping—backward. They drift into medicine with its failures. Their offices are antique shops. The garret museum has been moved downstairs into their offices. This group are always in the way; they act as stumbling blocks.

If the Chiropractic straight group-mind has a definite and positive specific for the CAUSE of all dis-ease at its command, and this is what the earnest, sincere, and honest medical group-mind has been constantly and consistently seeking; if the medical group-mind IS earnest, sincere, and honest in seeking that which the Chiropractic straight group-mind now has; and even tho the medical hypothetical premise of shot-gun methods be wrong; the very sincerity, earnestness, and honesty of the medical group will reverse the medical wrong hypothetical shotgun premise to A SPECIFIC CAUSE premise, and they will get what we now have.

If the Chiropractic mixer group-mind continues to fight for the "right" to use medical shot-gun methods which medical men are definitely opposed to continuing using; and if our majority mixer-group-mind desires to continue to use the sick as a sole means of making a living off of; and if this majority mixer group-mind doesn't care about the principle and practice of A SPECIFIC for the CAUSE of all dis-ease but prefers to use medical shot-gun modalities at any sacrifice in preference to the specific for the CAUSE of all dis-ease; and even tho our straight Chiropractic minority group-mind with its specific for the CAUSE of all dis-ease be right; the insincerity and lack of any definite earnestness and honesty of purpose upon the part of the Chiropractic mixer group-mind to humanity will cause our profession to lose that which they now have.

That this reversed medical evolution from medical shot-gun treatment modalities, to absorbing the Chiropractic specific of the CAUSE of all dis-ease, in principle, IS TAKING PLACE now between the two professions, is obvious to all who are closely observing the rapidly changing products of the scientific medical laboratories of the world. That they are absorbing this work only IN PRINCIPLE, at present, means that, given time, they

will absorb us IN PRACTICE as well. To better understand this, I suggest students read LIVINGSTONE—THE RECIPROCAL LINK BETWEEN LIFE AND HEALTH.

There is this cheering effect within the past year. HIO system was advanced and has been generally adopted by our profession, and, since the SPECIFIC FOR THE CAUSE OF ALL DIS-EASE has been produced at this institution; and has been presented, taught, and demonstrated at various places in the U.S., including our institution, the Chiropractic profession—both straights and mixers—have been rapidly accepting it in lieu of all former practices. Many former straights have become ardent advocates of this new torqued work. Many mixers have completely evolved their practices, thrown mixing modalities out, and replaced them with this work. The reports we constantly get, of better and quicker results on the sick, justified not only themselves but us as well, in continuing advocating this work with more emphasis than before. If the replacement value will step itself rapidly enough, it is yet possible for the Chiropractic profession to save Chiropractic for themselves. The pace now being set makes me optimistic for the future of our work.

SMALL THINGS ARE LARGE

A slip on the sidewalk, in winter, is a SMALL thing. It happens to millions. A fall off a ladder, in summer, is a SMALL thing. This happens to millions. The slip or the fall subluxates an atlas or axis. That specific subluxation is a small thing. The atlas or axis produces pressure upon spinal cord, with its trillions of fibres. That pressure is a SMALL thing. This specific pressure produces interferences and reduces flow of life force. That decreased flow is a SMALL thing. That decreased quantity flow of mental impulse supply produces a specific dis-eased brain or body. THAT is a BIG thing to THAT person. Multiply THAT man by a thousand, and you control the physical and mental welfare of a city. Multiply THAT man by a million and you shape the physical and mental destiny of a state. Multiply THAT man by 120 million and you forecast and prophesy the mental and physical status of a nation.

So, the slip or the fall; the creation of an odontoid specific subluxation, consequent pressure, reduced flow of mental impulse

and dis-ease IS BIG enough to control the thoughts and actions of a nation.

Now comes a man; and any one man is a SMALL thing. This man gives a specific adjustment upon the specific subluxation; and that adjustment is a SMALL thing. The adjustment replaces the odontoid specific back in normal alignment, and that is a SMALL thing. The adjusted subluxation releases pressure upon nerves; and that is a SMALL thing. The released pressure restores health to A man, and THAT is a BIG thing to THAT man. Multiply THAT man by a thousand men, and you step up the physical and mental welfare of a city. Multiply THAT man by a million, and you increase the efficiency of a state. Multiply THAT well man by 120 million, and you produce a healthy, wealthy, better race for posterity, in a nation.

Man is a SMALL thing, worlds considered. An axis vertebra is small, man considered. The odontoid process, on an axis, is small. An atlas is SMALL, man considered. The neural canal, in an atlas, is also SMALL. Yet, that axis odontoid process, small as it is; crowding in upon the atlas neural canal, small as it is, acts as a governor to the destiny of man's thots and functions; for it, in normal position permits a free flow, or in subluxation interferes with a free flow of all that force with which man thinks and acts. Man lives when he CAN think and act. Man dies when he CEASES to create thot and perform motion. Man becomes sick when thot and function are below par. Therefore, the inter-magnum-atlas foramen or the odontoid process may be a SMALL thing, but it is the BIGGEST thing in man.

So, atlas or axis specific adjustment of the inter-magnum-atlas foramen or odontoid specific subluxation, to release pressures upon nerves, to restore normal quantity impulse flow, to restore health IS BIG enough to rebuild the thoughts and actions of the world.

The atlas or axis is a lever that opens or closes the tube passage thru which flows energy which controls quality of thot, in the brain, by static stoppage of flow above; and quantity of function, in the body, below, by active stoppage of flow. The atlas or axis is a rheostatic switch, located close to the human-dynamo-generator; on the path of the great main feed-line; which, because of multitudinous potential and practical pos-

sibilities, can cut current flowing into any number of fibres from one to all; from fraction to totality; from one part of the body to its entirety. The atlas or axis, by opening or closing, controls living or dying processes and can make a man all present or all absent; make him half here or quarter gone. Any one thing, at any one place, which controls force-flow, is a dominant factor for damage, if it stops it; a dominant factor for good, if it releases it. In the hands of an incompetent fiend—one whose objectives are unsound—the hand that controls that switch, that turns OFF power, can darken the human city and commit human murder, even tho slowly. In the hands of a competent friend—one whose objectives are sound—the hand that controls that switch, that turns ON power, can enlighten the nation and fool many a physician, surgeon, or undertaker. And, it takes so little to turn that switch on or off. Any adult can learn how. It is a powerful weapon, for good or ill, in the hands of humanity, for the welfare of humanity. If a person uses this switch to extract money from the sick, caring little whether he turns it on or off, that person is a menace to society; a criminal in desire, and his hands should be padlocked OFF that switch, and his feet leg-ironed so he cannot reach it. If a person approaches this switch desiring to help humanity secure MORE POWER to think clearer, purer, and better thoughts, that man is a benefactor of the race; a humanitarian in desire, and his hands should be assisted to stretch out to reach every human atlas or axis switch; his feet should have wings, that they might reach them faster; obstacles in his path should be removed; hurdles cast to one side. THAT SWITCH IS THE GREAT SPECIFIC BETWEEN GOD AND HIS MAN; for with that switch OFF, God is partially absent and His man is sick, insane, criminal, and a fiend in destructive thots and actions. THAT SWITCH IS THE GREAT SPECIFIC BETWEEN GOD AND HIS MAN, for with that switch ON, God is entirely present in His man and he is well, sane, law-abiding, and a friend in constructive thots and actions. The value of learning how, and the ability that can turn ON human specific switches, is beyond computation, in the bigger sense. We do know what it costs our country alone to care for the unfortunates whose switches are TURNED OFF—hundreds of thousands of bodies and billions of

dollars annually to incarcerate their slow-running power-off bodies and care for them. The value of learning how, and the ability that can turn on human specific levers, is within computation, in the smaller sense, because we know the cost of the upkeep of its destructive product, even tho none can evaluate the love of a loved one. Great is any controlling factor; between God and man; power and its expression; the simple control of life! The atlas or axis switch-lever is a SMALL thing but it is MIGHTY. Flood-gates open millions of gallons of water, to millions of desert arid acres and make them bloom and yield fruit and cereals to feed the world; but, THAT'S a small thing compared to the switch-lever specifics which open and keep open paths to transmission of unlimited intellectuality between SOURCE IN GOD AND EXPRESSION IN MAN; that make millions of men, muscles and minds work normally. That's how BIG a knowledge of THE SUBLUXATION SPECIFIC and THE ADJUSTMENT SPECIFIC is.

Can there be a material economic valuation placed upon universal use of practice of subluxation specific and adjustment specific, in the human family? To imagine its universal use, is to comprehend obliteration of tremendous drag now present on pocketbooks of healthy, supporting the sick.

(We suggest our readers study "Problems" by this same author.)

CHAPTER II.

EVER-PRESENT ENIGMA



HY is there a reason for a SPECIFIC?

HY is there a reason for a specific FOR CAUSE?

HY is there a reason for a specific for cause of ALL DIS-EASE?

HY is this specific cause found only in cervical region of spinal column?

Why is this specific cause not found anywhere else in spinal column?

Why is the specific cause found only in superior cervical vertebrae and not in lower vertebrae?

Why do I say that the ONLY place in the human spinal column where you can have:

- (a) a vertebra OUT OF ALIGNMENT with its co-respondents above and below
- (b) where there IS OCCLUSION of a foramen or foramina
- (c) where there IS PRESSURE upon nerves
- (d) where there IS INTERFERENCE with transmission of the normal quantity flow of mental impulse supply between brain and body,

is at the atlas and axis region, including inter-spaces between them and atlas and occiput?

Why do I say it is impossible to have a vertebral subluxation below the axis?

Why do I say no chiropractor EVER HAS OR EVER WILL adjust a vertebral subluxation BELOW the axis?

Why do I say no sick person has ever GOTTEN WELL because of any chiropractor ever HAVING ADJUSTED a subluxation BELOW the axis?

Why do I say that it is impossible to have any misalignment with occlusion, with pressure, with interference at any intervertebral foramen, anywhere else along spinal column, in lower cervical, dorsal, or lumbar vertebrae?

Why is "Once a major, always a major"?

These and more questions keep coming up. They demand reply. If they are, an answer exists. What are those answers?

Four years ago, knowledge of the specific wasn't even a dream. Three years ago, it was a silly lie. Two years ago, it was half truth. Today it is! Tomorrow it will be an axiom.

We may be excellent students, but almost never scholars; learned, but not wise; broadly informed, but not experienced—for time produces understanding, and understanding is the essence of wisdom.

Illustration No. 3.

Normal positioned atlas and axis, lateral view enlarged. Note that each is level unto each other, and sitting as they should be in proper articulation with each other.

Illustration No. 4.

Atlas and Axis anterior-posterior view, enlarged; showing normal articulatory arrangement between atlas and axis.

Illustration No. 5.

Lateral view of cervical and inferior portion of skull, showing condylar articulation between occiput and superior of atlas. Note location of transverse process of atlas between ascending ramus of mandible, inferior to mastoid process of occiput. Note location of spinous process of axis.

Illustration No. 6.

Atlas and Axis lateral view, enlarged, to show plane lines.

Illustration No. 7.

Atlas and Axis anterior-posterior view, enlarged, showing plane lines.

Illustration No. 8.

Lateral view of cervical and inferior skull region, showing plane line, occiput, atlas, and axis, normal position.

Illustration No. 9.

Posterior view cervical region, inferior portion of skull, showing plane lines of occiput, atlas, and axis, normal position.

In taking photographs of illustrations 10 and 11, it must be remembered these were taken of a skeleton wired with steel rod running thru neural canal. It was impossible to get them level as they should be in the picture; but plane lines do show the position of occiput, atlas, and axis being parallel to each other in Illustrations 10 and 11.

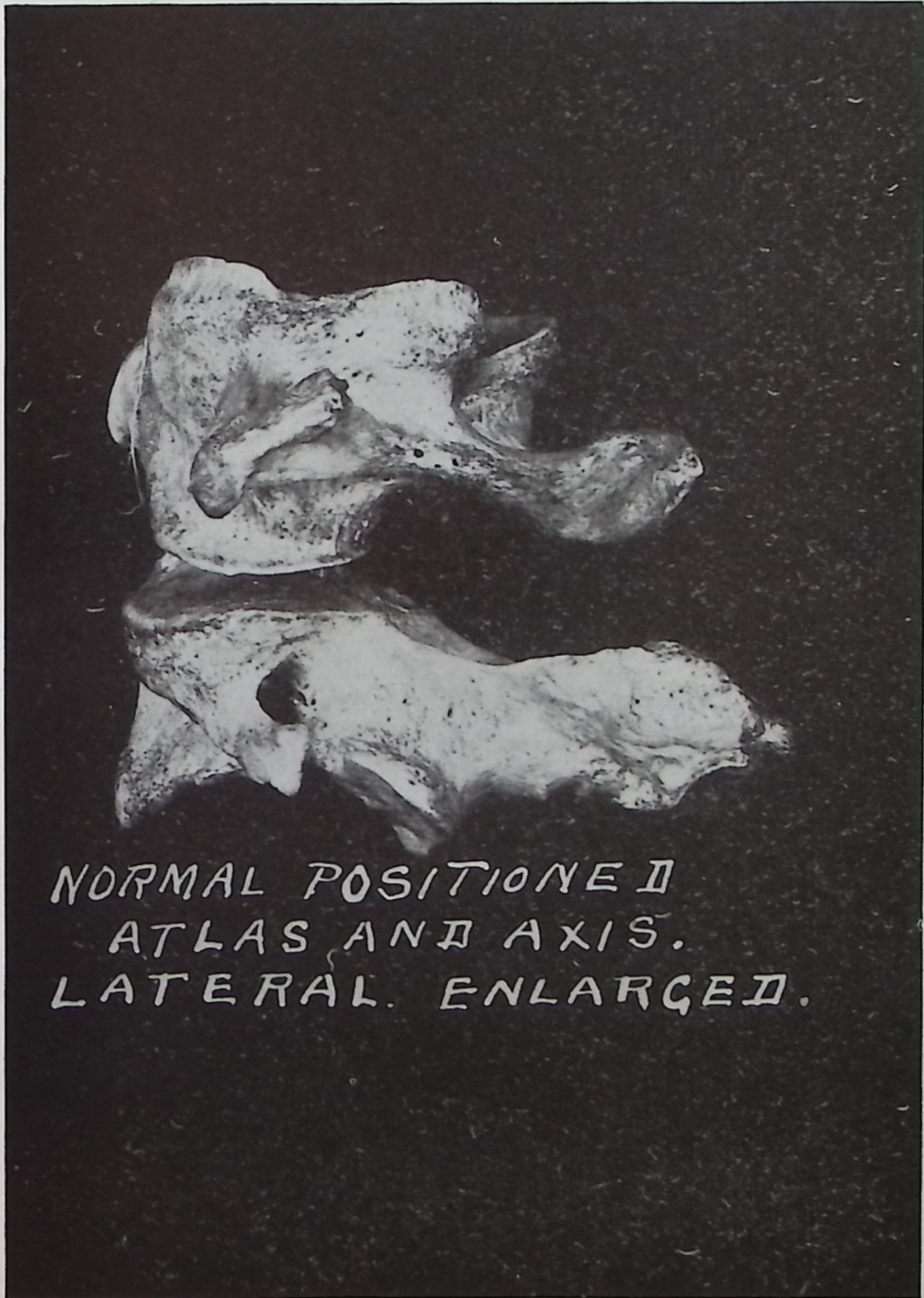


Illustration No. 3

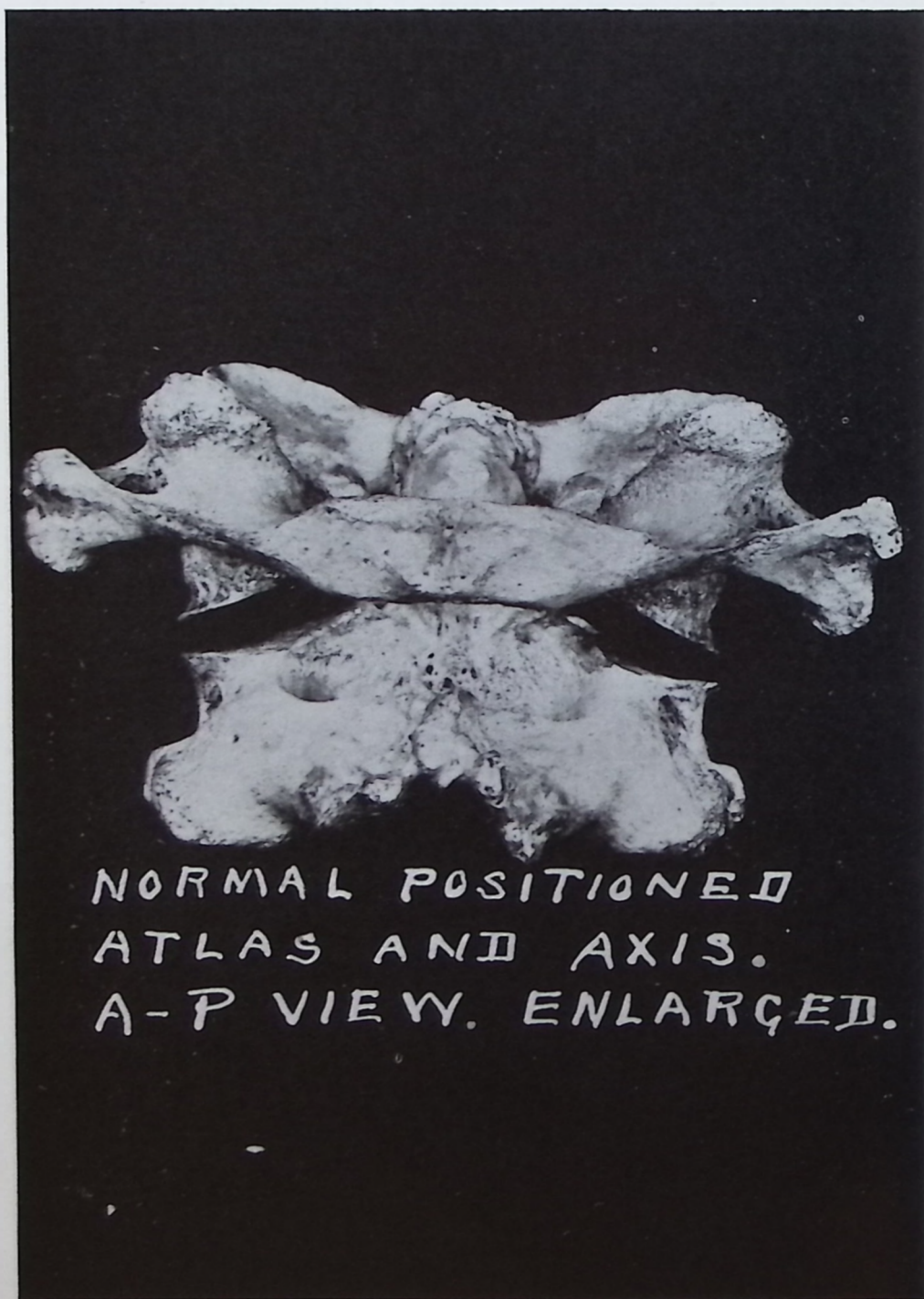


Illustration No. 4

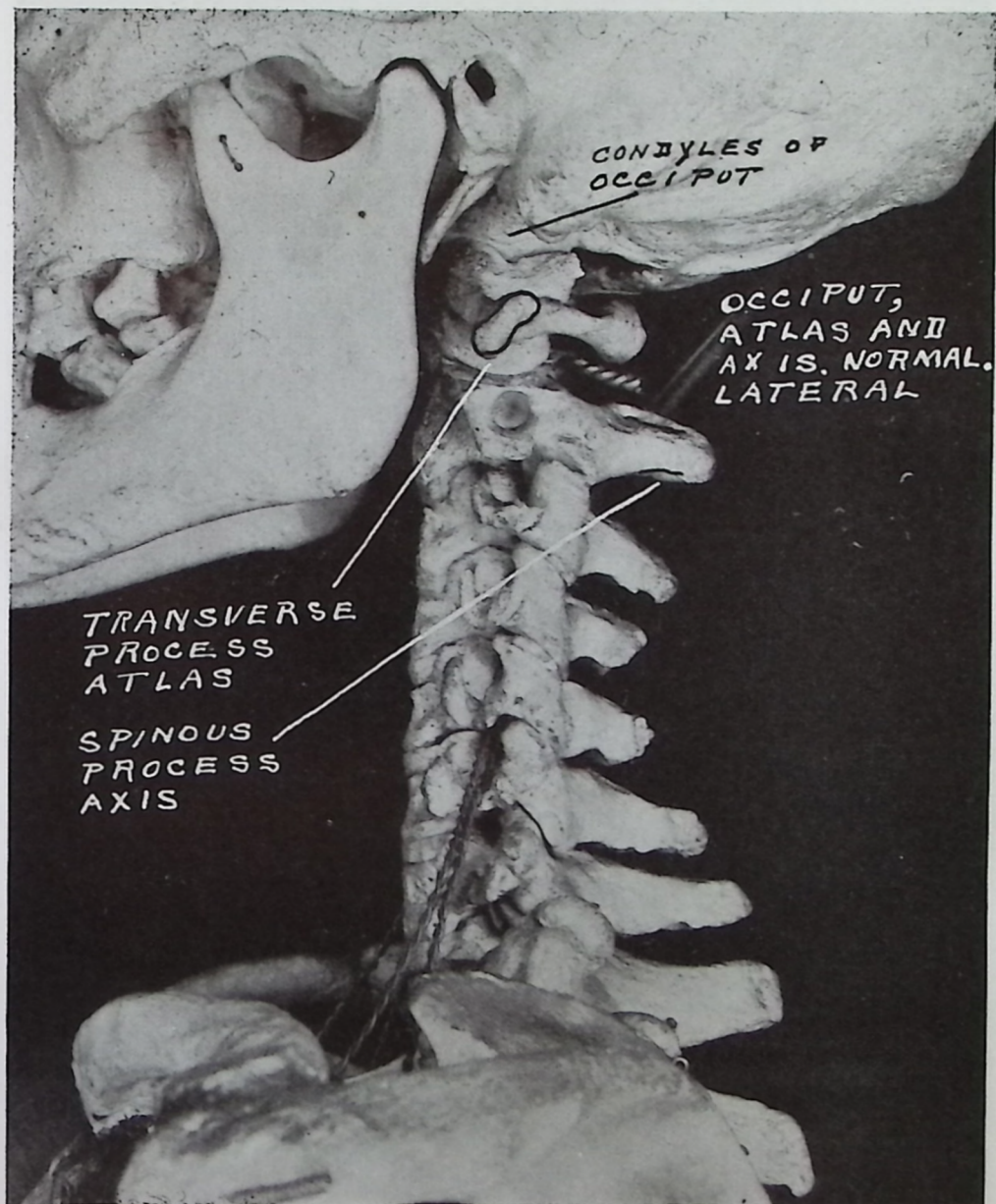


Illustration No. 5

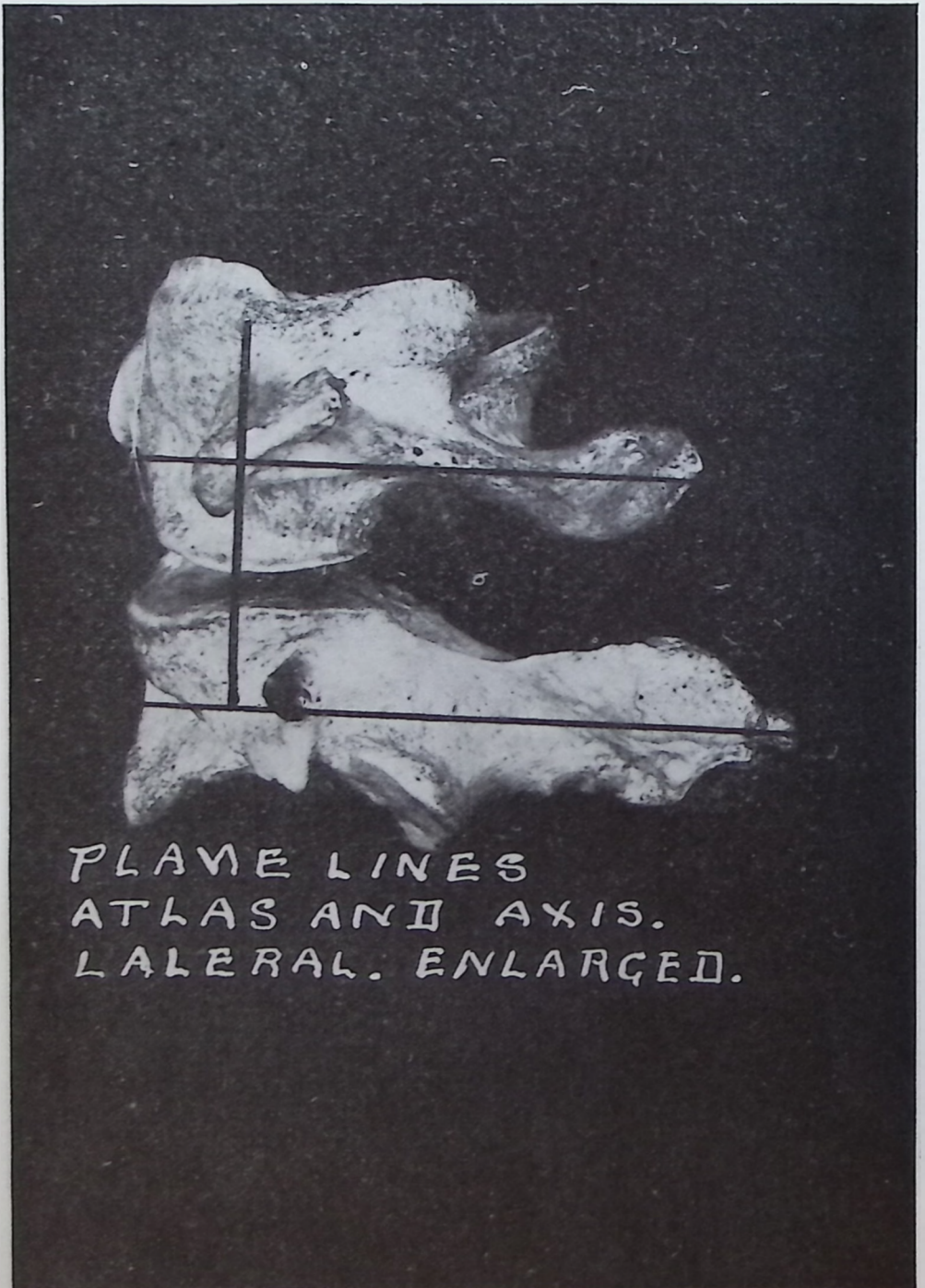


Illustration No. 6

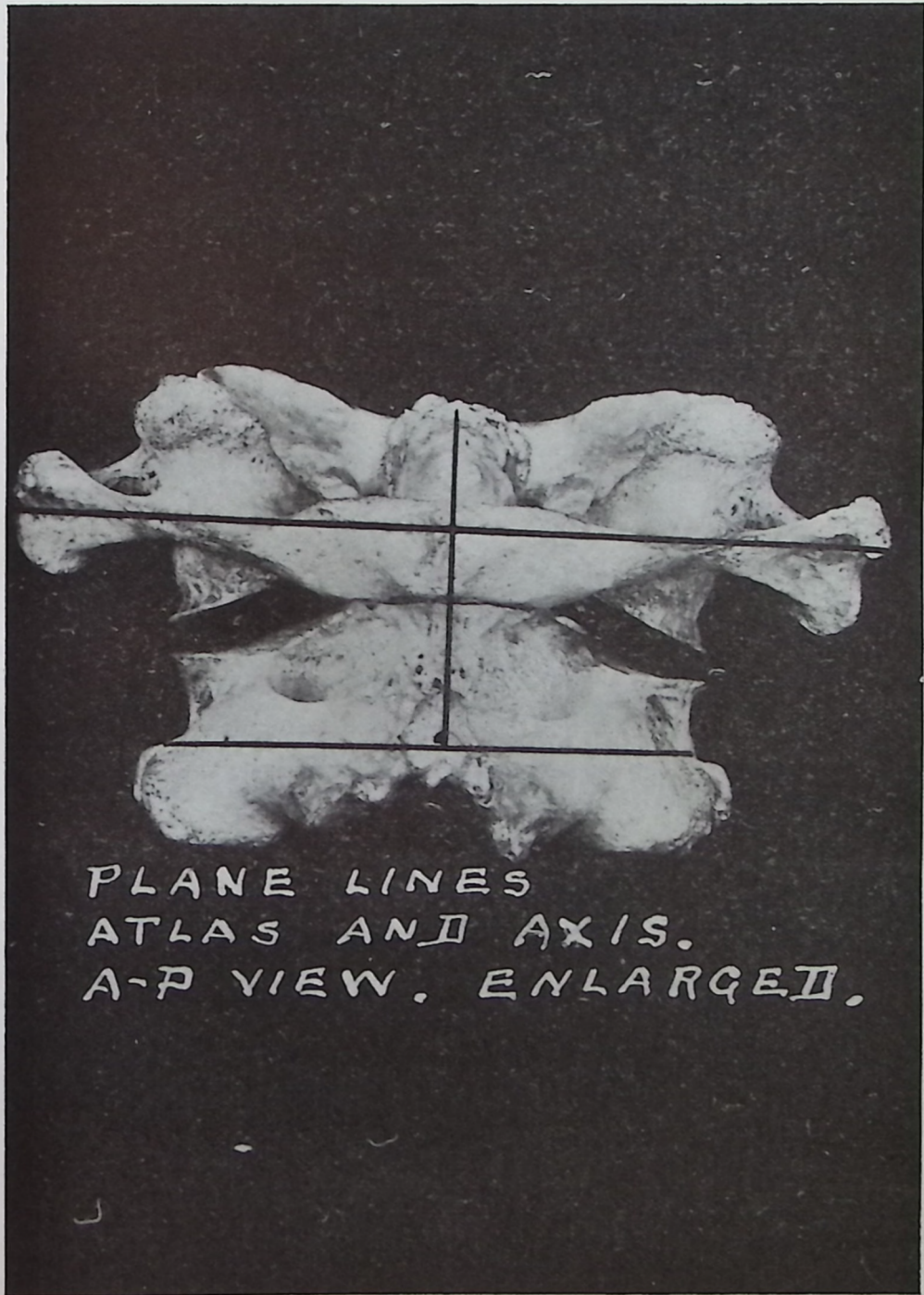


Illustration No. 7

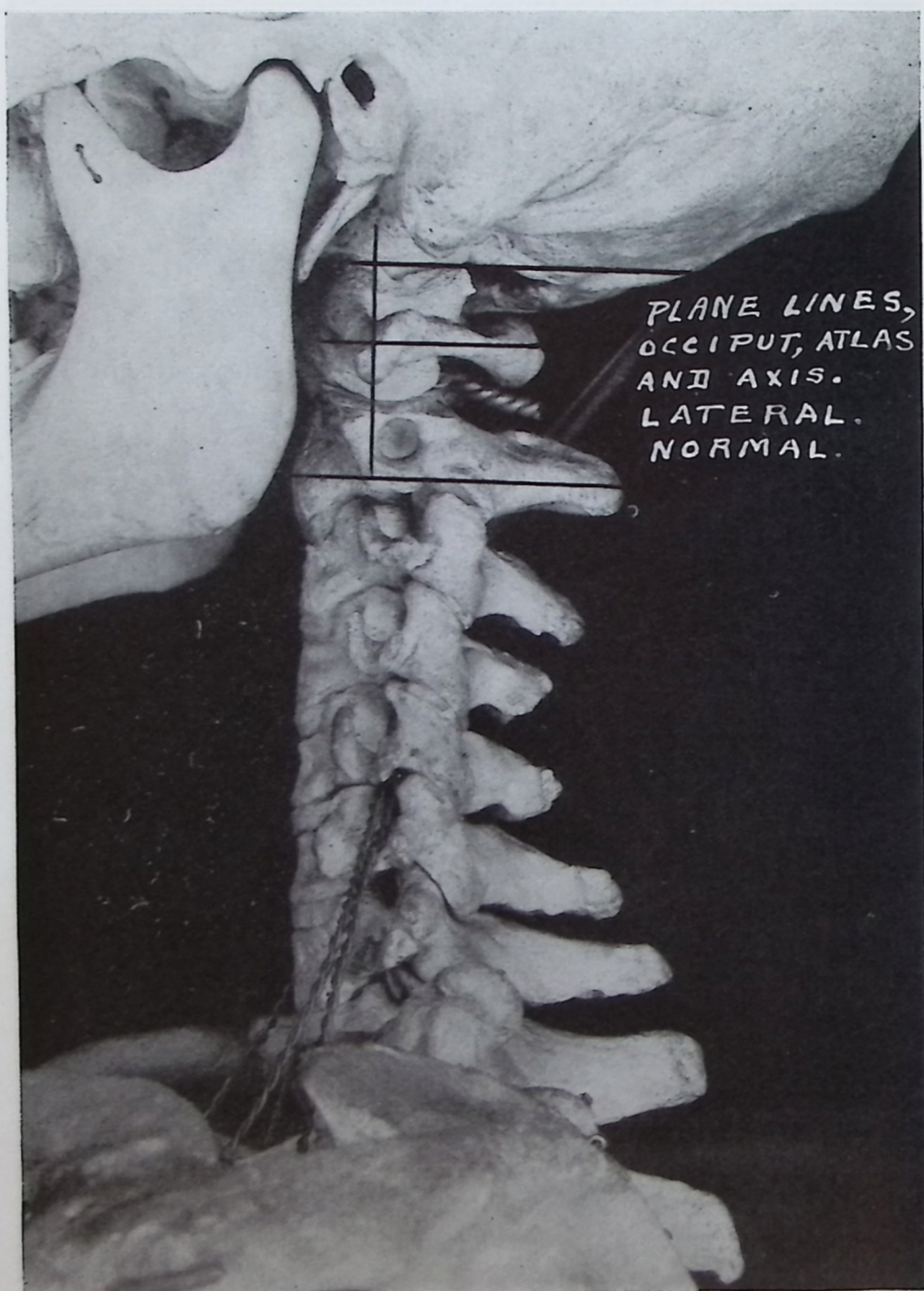


Illustration No. 8

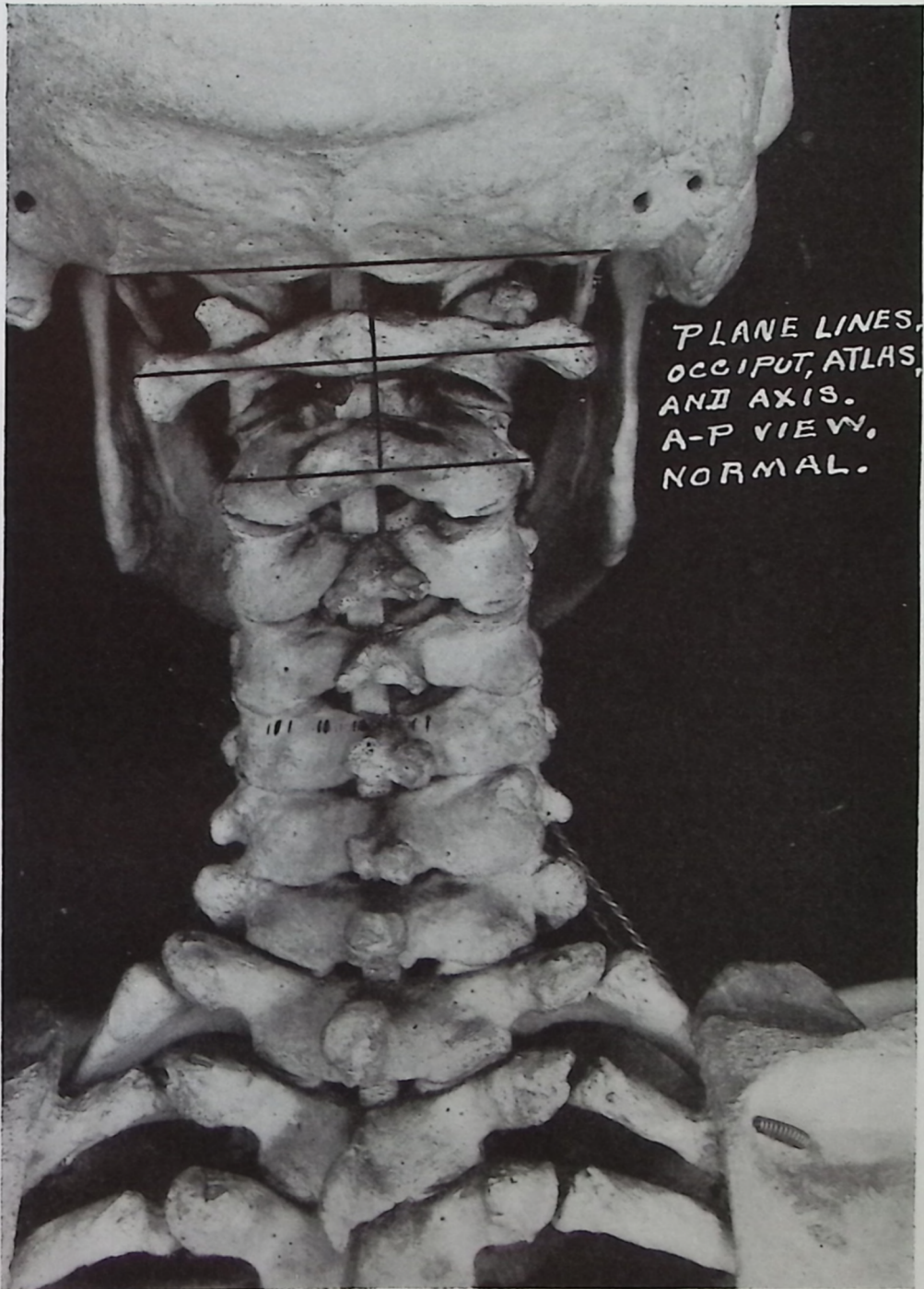


Illustration No. 9

CHAPTER III

DEFINITIONS



NEW work IS new work because it brings forth new explanations, differing from older explanations; therefore either demands new terms with present-day explanations; or using older terms with newer understandings and explanations. With this explanation, therefore, we now introduce a glossary of some new terms with their modern applications; or old terms with the understanding we have of them now.

Old terms are here used in the NEW sense. Unless each word is read with NEW understanding, its application will have been lost. NEW interpretations of OLD terms bring forth NEW definitions. If, as you read, you are in doubt as to intended NEW meaning, we suggest you refer to this glossary of NEW definitions of OLD terms. Some definitions include less than formerly; others more. Some are broadened, others narrowed in principle and practice. In no sense does any change any principle or practice from the original conception of Chiropractic.

“Interodontoidean space”
“inter-magnum-atlas-foramen”
“torque” “toggle” “recoil”
“torqued subluxation”
“torque adjustment”
“superior brain congestion”
“inferior body starvation”
“true subluxation”
“false subluxation”
“median line”
“plane lines”
“cause” “effect”
“superior,” “inferior,” “high,” “low”
“misalignment”
“subluxation”
“adjustment”
“neurocalometer”
“spinograph”

MISALIGNMENT—SUBLUXATION

MISALIGNMENT is a condition of three correlated vertebrae, less than a SUBLUXATION, which possesses all the former elements of what we then construed as a SUBLUXATION, but which is NOT a SUBLUXATION in fact. A MISALIGNMENT could be a vertebra out of alignment with its co-respondents above and below; palpation would reveal all the former elements of a "subluxation" as formerly construed by palpation in this abnormal relationship; spinograph would prove existence of MISALIGNMENT and under former constructions would call it a "subluxation"; it could have contiguous taut fibres, tender nerves, or contracted muscles; and under former construction would be called a "subluxation"; it could even have contiguous to itself on one or both sides NCM nerve pressure heat peak readings—and still not be a SUBLUXATION in fact. A MISALIGNMENT could as well exist in a dead body as in a live one. (See definition of SUBLUXATION by contrast).

ALIGNMENT is a condition of three correlated vertebrae when they are in apparent approximate normal relationship to each other and does not prevent any elements noticed under MISALIGNMENT.

REALIGNMENT is what might happen to a vertebra as the result of an action upon the part of an external agency; using applied force, either violent or passive, internal or external, which changes a MISALIGNMENT to an ALIGNMENT; in which any one or group thereof, or all of the elements which make a MISALIGNMENT may be eliminated, or present. To REALIGN a MISALIGNMENT into an ALIGNMENT may or may not TEMPORARILY change any elements of one to that of the other, but would only do so PERMANENTLY accidentally.

SUBLUXATION is a condition of three correlated vertebrae, more than a MISALIGNMENT, which have in part lost their normal relationship in juxtaposition, where it DOES occlude a foramen; DOES produce pressure upon nerves; DOES offer interference to transmission; DOES create resistance to transmission of mental impulse supply between brain and body, and DOES thereby become THE cause of dis-ease in one or multiple places in the body below or above.

SUBLUXATION can be ascertained as to location ONLY by the use of some delicate and sensitive instrument which CAN ascertain presence of above existing elements. A SUBLUXATION may or may not possess any or all of the elements present in a MISALIGNMENT; none of which, if present, makes it a SUBLUXATION; none of which, if absent makes it any less a SUBLUXATION. A SUBLUXATION can exist only in a LIVE body.

A SUBLUXATION could have any, all, or none of the earmarks of a MISALIGNMENT, but a MISALIGNMENT would have only some or none of the earmarks of itself and none of those of a SUBLUXATION.

Whenever the word "subluxation" is used with quotation marks (" "), it signifies the term is used as formerly applied to what is NOW construed as a MISALIGNMENT for purposes of contradistinction between the terms as EXACTLY applied NOW to a SUBLUXATION and as loosely applied to a MISALIGNMENT which may be termed a "subluxation" when it is in fact not such.

Example: The case had ONE SUBLUXATION but there also appeared SEVEN MISALIGNMENTS, all 8 of which were formerly called "subluxations."

ADJUSTMENT is the result of an action upon a SUBLUXATED vertebra, upon the part of a CHIROPRACTOR, using external applied force, meeting with internal resistance force upon the part of a live sick patient, intentionally located and intentionally positioned, which changes a SUBLUXATION to its normal apposition with its superior and inferior co-respondents, which information is secured by the competent use of an NCM to secure knowledge of LOCATION and the use of a SPGH to secure knowledge of POSITION; which, because thereof, reopens the occluded foramen, releases pressure upon nerves, reduces interference to transmission, lessens resistance, and restores transmission of mental impulses between brain and body, and does thereby ADJUST the cause of dis-ease in one or multiple places in the body below, or above. An ADJUSTMENT can be given only to a living body.

"THE ADJUSTMENT WITH THAT EXTRA SOMETHING" is the SUBLUXATION that is ADJUSTED which remains in

normal situ for an extended period of days or weeks; which makes possible A CONTINUED open foramen; which permits a long CONTINUED flow of mental impulse supply; which gets cases well quicker and reduces the number of places to "adjust"; proves that each ADJUSTMENT is such in fact, and makes possible a definite knowledge of WHERE, WHEN, and HOW to ADJUST. "The adjustment with that extra something" releases interference at one place without creating more at others; thus making it THE HOLE IN ONE ADJUSTMENT.

"The adjustment with that extra something" is the net result of the additional accumulative constructive survival value that accrues as a result of an exclusive Innate recoil ADJUSTMENT upon a SUBLUXATION which was the major in each case. It is the marked brevity of time and rapidity with which cases get well in contrast to the long time and slowness with which cases formerly got well, even tho by accident, wherein the case is "adjusted" upon many "subluxations" none of which were ADJUSTMENTS upon THE SUBLUXATION which was THE cause of that case's sickness.

Whenever the term "adjustment" is used with quotation marks (" "), it signifies that the term is used as formerly applied to what is now termed a "subluxation" for purposes of contradistinction between the term as EXACTLY applied to a SUBLUXATION and as loosely applied to a MISALIGNMENT when it is in fact not such. Example: You can give an ADJUSTMENT to a SUBLUXATION but you can only "adjust" a "subluxation." To do anything to a SUBLUXATION is to attempt to give it an ADJUSTMENT. To do anything to a MISALIGNMENT is to REALIGN it, even tho loosely called an "adjustment."

"Permanently" is used here to mean what it implies and yet must be construed in an elastic sense for nothing permanently IS permanent. Example: A case today comes with a certain condition. We find THE major, give ADJUSTMENT, the case gets "PERMANENTLY" well. In another place I mention that "once a major always a major." The case returns at some future date with a different condition, and the SAME major should be ADJUSTED. Was the original ADJUSTMENT "permanent"?

Yes, for the first condition; no for the second. Comparatively, some things are more permanent than others.

NEUROCALOMETER is a sensitive, delicate, comparative heat reading instrument which locates interference to transmission of mental impulse supply between brain and body; which locates all nerve pressure heat reading interferences BEFORE an ADJUSTMENT and discriminates, by process of elimination, which ones represent TRUE INTERFERENCES and those which are but the effects and symptoms of interferences at more distant or remote places in the spinal column area of a sick man. Its use, intelligently interpreted, instructs a Chiropractor whether his case is getting better or worse; whether he has located the SUBLUXATION or not; whether he has given an ADJUSTMENT or an "adjustment," or not; whether any or all other readings are dependent or independent of the one he is ADJUSTING for. It proves which readings are direct, which are indirect; which places are SUBLUXATIONS, which ones are MISALIGNMENTS.

SPINOGRAPH follows competent use of an NCM and gives a true picture of position of all vertebrae in vertebral column region, determining where there exists a SUBLUXATION as found by NCM. It gives information as to direction of ADJUSTMENT to accomplish objectives sought as defined under ADJUSTMENT.

INTERODONTOIDEAN SPACE

(To get "interodontoidean space" fixed in mind, in building up an understanding of this entire subject, we suggest you study A-P Spinographs, featuring this particular point.)

By "interodontoidean space" is meant that interval of area that normally or abnormally exists between odontoid process of axis and lateral mass on left and right of atlas thereof. It also applies to the possible abnormal space that can exist, with the torqued subluxation of either atlas or axis, between anterior of odontoid process and fovea dentalis articulation on posterior of anterior arch of atlas.

The odontoid process of axis could be mal-positioned to left and crowd left lateral mass of atlas.

The odontoid process of axis could be mal-positioned to right and crowd right lateral mass of atlas.

Theories give way to facts. Facts are attained by research.

Research is reached by taking a problem and proving it from optical ways; accumulating what is revealed and eliminating all not revealed. It would be illuminating could we reproduce ALL spinographs taken, in ALL cases spinographed, each with its multiplicity of positions to bring research and what it reveals to you. To do so would be to fill a book many times the size of this.

We are asked, "What significance is there to difference in interodontoidean space, right and left of lateral masses, in various wedge-side-slip atlas sublaxations?" To answer THIS problem we took several cases, spinographed "natural" A-P and lateral views. Determined that atlas-wedge-side-slip sublaxation WAS, then straightened head, shifted it to left, then to right, etc. This does not shift rightangle penetration direction of X-ray, but gives a different angle of deflection of shadow on film, which approximates distance observed on one side or other and increases or decreases distance between lateral masses and odontoid, left or right.

(See Illustrations 50-59 with conclusions, which throw light on this question of how forced positions of head change facts revealed in Spinographs.)

The odontoid process of axis could be posterior in neural canal of atlas, either because of an anterior atlas or a posterior axis.

The odontoid process of axis could be posterior and to left or right in neural canal of atlas, either because of an anterior torqued atlas or a posterior torqued axis.

In any event, there is created an abnormal position of odontoid process in relation with its fovea dentalis, which creates a necessity for a term to express the hiatus in position, therefore the "interodontoidean space," could be variously described and is so done in another portion of this work.

The odontoid process of axis could be anterior at its base and posterior at its apex, in relation to fovea dentalis of atlas.

The odontoid process of axis could be posterior at its base and anterior at its apex, in relation to fovea dentalis of atlas.

"INTER-MAGNUM-ATLAS-FORAMEN"

(To get "inter-magnum-atlas-foramen" fixed in mind, in building up an understanding of this subject, we suggest you study Illustrations 23, 24, 25 and 65, featuring this particular point.)

Wedge-side-slip atlas sublaxation brings to light a new abnormal relationship of how movement of atlas right or left decreases

size, shape, diameter, and circumference of neural canal between inferior of magnum foramen and superior surface of atlas, creating BETWEEN a foramen subject to constriction pressure, hence interference of mental impulse flow from above downward. Left side-slip produces pressure on right of neural canal. Right side-slip produces pressure on left of neural canal. There is also present pressure from posterior ring of atlas according to whether atlas is anterior superior, or anterior inferior.

“TOGGLE” “RECOIL” “TORQUE”

To “toggle” an action is to utilize a double-joint action where little force is stepped-up, by concentration, and made to do much work with little effort. One joint action is to shear. Two joint action is to double-shear, or to “toggle” the shearage value. A single shear action is exemplified in a pair of scissors. A double shear action is exemplified in a pair of bolt cutters. In a bolt cutter, we have a scissors-shear in one joint, which is then advanced on to the toggle-shear in the second joint.

To “recoil” is to introduce speed in delivery, so that there rebounds a “recoil” in return as a direct result of the onward delivery. To “recoil” a “toggle” is to take the double-jointed concentration of an onward shearage value and increase its shearage value by introducing into the cutting action, speed.

There is a law of ratios which multiply geometrically and also by reverse order. To “shear” with one joint, could be called 1. To “cleavage” by two joints is to step-up the 1 by 10. To “recoil” the “toggle” of 10, is to step it up to 1,000. The reverse would also be true. As you step-up the scissors to a toggle; and the toggle with a recoil speed, you also step-down the amount of power used in inverse ratio. The 1,000 is 1,000 times easier with 1,000 times less energy than is the 10. The 10 is 10 times easier with 10 times less energy than is the 1.

A few years ago we used the term “toggle” adjustment, meaning that we then meant to attain that which we now more accurately and correctly call the “torque” adjustment.

“Toggle” is a term NOW used to express A KIND of a mechanical action which concentrates forces to do work. “Recoil” is a term NOW used to express an additional KIND of a mechanical action which concentrates speed to do work. “Toggle” is a

double-joint action. "Recoil" is speed added to that double-joint action. To "torque" a "toggle-recoil" is to indicate the DIRECTION OF DELIVERY of the "toggle-recoil" movement.

To "torque" is to corkscrew in a three direction movement simultaneously. The three directions are:

up or down, S or I,
to left or right, L or R
around, circularly, obliquely, a combination.

The average mind can readily understand, see, visualize ONE direction. A lesser number grasp and understand TWO directions. FEW appreciate motion when directed THREE directions simultaneously. "Torqued subluxations" and "torqued adjustments" involve THREE directions.

When the Chiropractor studies an A-P and lateral spinograph, and sees a vertebra that is off its natural planes, out of normal levels; is so wrenched, twisted, kinked, that it takes three distorted directions at one and same time—then he sees a "torqued" subluxation.

To see "torqued subluxations," it is advisable to have TWO view-boxes, having A-P and lateral views of the case alongside each other, so that eye and mind can blend distortions as revealed by one with distortions as revealed by the other, thus getting a combination position of what BOTH reveal.

(See Illustration No. 132 to understand what we mean.)

At first you will have difficulty in seeing the kink twist, except in the worst cases. Keep seeking; you will see it in all—some more, some less. Here again, the same as in all phases of our work, you will need keep checking yourself. You will unconsciously be slipping back into reading films the OLD way, and your percentage of results will drop. CHECK UNTIL IT HURTS, ALWAYS, IN ALL WAYS.

(See Author's article on SLIPPING AND CHECKING.)

When the mind understands what the spinograph reveals, then hands are ready to follow thru in reversing abnormal to normal; to correct the "torqued subluxation" by "untorquing" it with a "torque adjustment." This consists in so delivering a force, from mind to hands; from hands to vertebra, that by its reversing direction, will reverse the THREE directions into a normal position.

With the understanding we NOW have about "torqued" atlas and axis subluxations, as seen, analyzed, understood and adjusted, no ADJUSTMENT is ever given unless THE TORQUED VERTEBRA IS UNTORQUED; until the three-direction locked vertebra is three-direction unlocked; with its "staying-put value" in exact ratio as the three-direction production is reversed to a three-direction reduction; as the torque is untorqued; as the lock is unlocked. If completely reversed, untorqued, unlocked the FIRST time, it WILL BE adjusted and WILL stay put. If merely shoved, pushed, or jarred in one or two directions, temporarily loosened, it will return to its externally-created three-directioned locked position, with its returned torqued interference, even tho some pressure is partially and temporarily checked out and partial relief obtained. When that time arrives when Chiropractors become efficient and competent enough to accurately and completely untorque a torqued subluxation, from three directions, and do it ONCE and upon FIRST EFFORT, they will need give but ONE adjustment and it WILL BE adjusted to stay. As a surgeon "sets" a dislocation but once, so the Chiropractor will untorque ("set") a subluxation but once—and he will be paid accordingly, as a surgeon is. That day will arrive when a Chiropractor will consider it a badge of incompetence to be compelled to "reset" a subluxation more than once; or be "compelled" to keep pecking away, day after day, at a vertebral subluxation. I have occasionally said, in a jocular but serious vein, "Every day a Chiropractor pecks away at a subluxation, he should pay the patient \$5 for incompetence delivered; but when a Chiropractor ADJUSTS the subluxation ONCE and it stays, he should charge the patient \$500 for service rendered."

(Study Chapter XII more fully to get detail of how this is done.)

Just as it took courage to suggest the new principle of the HIO, and then later its practice, to the exclusion of all other principles or practices; so will it now take additional courage for our profession to make this next most important exclusive step upward in the solution of the positive, exacting, and definite specific. We have thoroly tested it in clinical research work for not less than one year before suggesting it to the profession. Desiring to increase your percentage and step-up your efficiency in getting Chiropractic problem cases well, in a quicker possible

time, with Chiropractic alone, we suggest you confine your interpretations of spinograph films to this new system; adjusting exclusively by your interpretation of them from this directional torque twist which always exists.

“TORQUED SUBLUXATION”—“TORQUE ADJUSTMENT”

For many years we have listed “subluxations” as of three-lettered directions. We are doing that now in relation to “torqued” subluxations. Today, a “torqued” subluxation takes on a fuller, more distinct, more scientific meaning as to its abnormal position as confined to atlas and axis region.

For many years we have referred to “a torque adjustment” but today it takes on many new interpretations of more limited area but in a more broad and direct application as to values which will be observed in studying various phases as outlined in this book.

In the past, a 3-lettered “torque” subluxation meant to correct the position of ONE vertebra only in relation with its co-respondents above and below, assuming co-respondents were almost normal in their dual relationships to one abnormal lying in between. Today, a 3-lettered “torque” subluxation includes in its understanding the direct effect such a torqued subluxation has in correcting consequent mal-positions of occiput upon atlas as well as adaptative curvatures in the cervical, dorsal, and lumbar regions, with their many minor mis-alignments at various, devious, and multiple places in their various, devious and multiple ways; all of which automatically correct themselves if, as, and when THE torque subluxation is correctly untorqued.

To “untorque a subluxation” with a “torque adjustment” would thus imply that it means to correct the mal-position of ONE vertebra for the purpose of permitting a normal adaptation to take place in all other misaligned vertebrae or adaptative curvatures in a spinal column, both superior to the torqued subluxation as well as inferior to it, which were abnormally adaptive to its original cause.

In the early years of Chiropractic, we used medical practice term “treatment” as THEY applied it to effects, notwithstanding WE worked on CAUSE. The obvious finally arrived that WE were correcting a MECHANICAL misalignment of a segment of the human line-shaft, therefore needed mechanical ADJUST-

MENT. A Chiropractor could not TREAT CAUSE. The term "adjustment" WAS added. Only thru clear understanding of PRINCIPLE of CAUSE, rather than EFFECT, could we feel free with its use. In the light of new information, SUBLUXATION could be called a LOCKMENT and practice an UNLOCKMENT. To "adjust" is to correct relationship of this with that. Two INANIMATE things could be "adjusted." To UNLOCK is to permit something to open between here now to there then, permitting something to pass thru which was locked out. I am not suggesting a change in terms; just a new possible way of expressing the old principle.

"SUPERIOR BRAIN CONGESTION"

"INFERIOR BODY STARVATION"

These terms are used almost, but not quite, synonymously. A torqued subluxation of atlas, or axis, so occludes the spinal canal at various places in various ways, that it makes it impossible for a normal, full quantity of mental impulse supply to flow onward from brain to body thru the obstruction. It can readily be understood that such an obstruction located at a vital intermediate space between brain and body, such as location of atlas and axis predetermines, would at once dam back an onward flow out of the brain, thus producing "brain congestion" of forces or energies made for the body but never reaching the body to be used by the body. The question of whether Innate Intelligence would soon adapt itself to a reduced production, knowing the forces cannot get thru, or cannot be used in the body, is vital and one we cannot answer at the moment of the production of this work. More study is needed before that can be reliably or authoritatively answered.

It is obvious that brain does manufacture a quantity of force sufficient for the needs of all its body below. If there is an interference, then force is sent down to interference and does not, because it cannot, get thru. Being approximate to brain, distance considered, this force is unquestionably dammed back and brain suffers with an excess of energy which becomes clogged within itself. This produces "brain congestion" of manufacture which is manifest in many types of mental symptoms which

are not directly attributable to direct brain dis-eases. How far-reaching such are is also another problem we cannot answer at moment of production of this work. More study is needed before that can be reliably or authoritatively answered. If results attained by adjustment of torqued atlas or axis is a criterion of what happens, then it is easily observed that brain or mental symptoms quickly disappear upon releasure of interference permitting "congested surplus supply" to get thru to the body.

Betwixt and between brain and body is THE place of THE SPECIFIC which interferes with transmission between brain and body. Interference reduces the normal quantity flow BELOW and dams it back INTO the brain. The absence below is the surplus above. The absence below gives an absence functional disturbance. The surplus above gives a surplus adaptative functional disturbance. Every case, regardless of location, organ or type, below, has an adaptative locality, organic and type of mental disturbance; in plus or minus. The brain-mental functional abnormality is balanced in off-set by its body-organic functional abnormality. If it were possible to correctly analyze either, the other would be discerned with equal accuracy; except that it would be its opposite form; meaning, if the body is starved the brain would be congested.

A torqued subluxation of atlas, or axis, so occludes the spinal canal, at various places in various ways, that it makes it impossible for a normal, full quantity of mental impulse supply to flow onward from brain to body thru obstruction. It can readily be understood that such obstruction located at a vital intermediate space between brain and body, such as location of atlas and axis predetermines, would at once produce body starvation of forces or energies made for body but never reaching the body to be used by the body. The body dis-ease problem has been one on which we as Chiropractors have given much thought, many years, and have seen changes take place when interference IS released and normal, full quantity has been permitted to flow onward into the body. The term "body starvation" as used here is not meant to imply food elements but an absence of energy necessary to keep tissue structures up to tone or normal functioning speed to make them produce a normal functional activity.

"TRUE SUBLUXATION"—"FALSE SUBLUXATION"

Later on in this book, this subject is gone into carefully and thoroly. Suffice to say here that these terms indicate where the element of "true" or "false" enters, is in difference in position of spinous process of axis wherein body of axis is always one way. In one instance body of the vertebra has a definite twist, wrench, or kink and spinous process follows thru in accordance with balance of its body. In other instance (the false) body of vertebra has the same definite twist, wrench, or kink, and spinous process does not follow thru but is bent to opposite direction and is not in accordance with balance of body of vertebra.

In listing true and false, they would be same as to directions, except for words "true" or "false" which indicate whether spinous process follows thru with its body, or is in opposite accordance. In adjusting true and false, they would be the same, as to directions, except for knowledge that one is "true" and other is "false."

Example: True PLI. False PLI. Both are PLI subluxations. In one, spinous process is to left of median line; in other it is to right of median line. The body of the vertebra of each is subluxated the same. In adjusting a "true" or a "false" PLI, they would both be adjusted FROM PLI to ARS.

"MEDIAN LINE"

Spinographs are taken TO REVEAL torqued subluxations, or their correction following adjustment. Spinographs MUST present the torqued subluxation, or its correction as it ACTUALLY, EXACTLY exists. Without this actuality, a spinograph has little if any value. To distort torqued subluxation; to show it other than as it exists, is to gain a distorted picture from which distorted conclusions would exist as to locations thereof.

In another part of this book, we have described a certain procedure for spinographic taking of torqued subluxations. It bears repetition. The spinographic table, more particularly that portion immediately under spinal column, more particularly that portion immediately over unexposed film, on that portion containing the full length Bucky diaphragm, running from above downward, thru its exact center, is a drawn line thruout its full length. In placing patient upon table, spinous process of first

sacral vertebra is placed IMMEDIATELY over inferior portion of this line in center of table. The patient so lies down that occipital protuberance is placed IMMEDIATELY over superior portion of that line in center of table. Thus both extremities are in conjunction with this MEDIAN LINE. All else in between sacrum and occiput assumes a place as the torqued subluxation places it. The spinographer taking pictures does not position any part of that spine. If the head leans to left or right, then it rests left or right on table, assuming whatever position torqued subluxation makes it assume. The spinographer sees only that the sacral spinous process and occipital protuberance are in alignment WITH THIS MEDIAN LINE.

(This subject is elaborated upon in Chapter VIII under heading "Care in Establishing Basic Facts.")

When spinographs themselves are developed and placed into view boxes for interpretation, he now has a true view of the vertebrae as they were and are. From the A-P view, a MEDIAN LINE is either mentally established or can be established by drawn lines upon the spinograph. The films are placed squarely in view box. A perpendicular plumb line is drawn beginning at superior tip of odontoid process, downward thru full length of spinograph. Anything to left or right of line is to left or right OF THE MEDIAN LINE. No longer do we draw lines thru tips of spinous processes; nor do we regard spinous processes as representative of center of median line, especially with cervical torque subluxations.

"PLANE LINES"

(See Illustrations No. 6, 7, 8, 9.)

(This subject is covered in specific form in Chapter XXVIII. We suggest you link that with this when studying this Definition.)

What two points on lateral view of skull help to determine the "plane" of occiput?

What two points on lateral view of atlas help to determine the "plane" of atlas?

What two points on lateral view of axis help to determine the "plane" of axis?

With reference to A-P view of cervical region, when it is said "if the occiput is low on the left (since "low" and "high" are relative) what are they "low" or "high" to?

In answer to any and all such general terms, we must understand that anatomy is subject to such terms as would be commonly understood as commonly used.

A normal human body SHOULD stand erect, meaning thereby that body should be plumb. What IS "plumb," surely is not a question of abstract imagination. If a "plumb" penciled line were drawn upon a wall and the human body faced it or backed up to it, that "plumb line" should normally bisect that body into two normal halves. If the body, as it stood as it would stand, such standing position being determined by its torqued vertebral subluxations with their many adaptative inferior changes, leaned too much to left or right of that line, then it should be said that it is to the left or right of a median plumb line.

If a normal human body IS standing erect, meaning thereby that the body IS plumb, then at exactly right angles to that "plumb line" we could easily establish a "level plane." What is a "level plane," is not a question of abstract imagination. If a "level" penciled line were drawn at right angles to "plumb line" upon wall and the human body faced it or backed up to it, then all bilateral dualities of the human anatomy should be on a "level plane." The two ears, eyes, shoulders, hips, etc., should be on a "level plane" to each other to correspond to adjustable heights of "level plane" lines at right angles to "plumb plane" drawn on wall. If one eye, ear, shoulder, or hip were "lower" than the "plumb-level-planes" then it could be easily said that ONE SIDE IS HIGHER OR LOWER THAN THE OTHER.

If head is normal in its erect posture, then the head should bisect the "plumb plane"; and if backed up to wall, the two eyes, two ears, two shoulders, two hips should be level with "level plane" to correspond to adjustable heights of "level plane" lines at right angles to "plumb plane" drawn on wall.

If head is normal in its "plumb" and "level" planes, then atlas, axis, and all other vertebrae should correspond to the same rule. But vertebral subluxations enter the picture. An atlas or axis becomes a torqued subluxation. An atlas may be anterior, right, and superior; or it may be anterior, left and inferior. The axis may be posterior, right and inferior; or it may be posterior, left and inferior. The inferiority on either lateral

side throws it off its "plumb plane" as well as off its "level plane." When such occurs, with an atlas or axis, it throws head ABOVE and body BELOW off THEIR "plumb" and "level" planes which creates adaptative "plumbs" and "levels" to establish a normal ADAPTATIVE EQUILIBRIUM. In the past we have attempted to "adjust" many of these, thinking them vertebral subluxations.

"CAUSE" "EFFECT"

The living vertebrate body contains an internal, resistive force, using intelligence to protect and preserve itself.

Outside the living vertebrate body is an always-present, invading force which, according to quantity and approach, can injure or benefit.

If external invading force is less than internal resistive factor;
or

If internal resistive force is greater than external invading force; or

If they are equal to each other, then neither would do damage to body structure to its integral integrity of its parts.

Internal forces working externally and external forces working internally often clash — a concussion of forces; a shock which could be destructive in accidental application.

If external or invading force overcomes internal resisting force, a vertebral subluxation can be one resulting injury to integral integrity of its osseous structure.

A vertebral subluxation is a vertebra out of normal articulatory relation with co-respondents above and below; wherein it is twisted, kinked, wrenched, torqued in three directions; wherein it is "locked" so that no internal force was sufficient to prevent its creation; wherein no internal force is sufficient in quantity to "unlock" and replace it.

Internal force was not great enough to absorb the external penetrating force.

Internal force is not great enough to correct its abnormalities when it was not great enough to prevent injury.

The torqued vertebral subluxation is permanently locked in abnormal position.

Permanent abnormal position produces permanent abnormal occlusion to a canal thru which nerves pass.

Permanent abnormal occlusion produces permanent abnormal pressure upon nerves.

Permanent abnormal pressure upon nerves creates permanent interference to transmission of mental impulse supply.

Permanent interference to transmission of mental impulse supply diminishes normal quantity flow of internal resisting, rebuilding health forces.

Permanent reduction in normal quantity of health force flow creates an accumulative destructive survival value, called dis-ease, reducing speed of action of motion of tissue cell structure.

Step by step, each abnormal cause produces abnormal effect.

EXTERNAL CAUSE was concussion of forces.

INTERNAL CAUSE is vertebral subluxation.

Reversing the order:

The living vertebrate body contains an internal, resistive force, using intelligence to protect and preserve itself.

Outside the living vertebrate body is an always-present, invading force, which, according to approach and quantity, can injure or benefit.

If external invading force is more than internal resisting factor; or

If internal resisting factor is less than external invading force; or

If internal is below par, and external at par; or

If, sometimes, they are equal to each other, one might work a corrective replacement to body structures of its integral integrity of its osseous structure.

External forces working internally and internal forces working externally can intentionally be made to set up a concussion of forces, the external being constructive in scientific application at a definite place, to accomplish a definite objective of forces, the external being constructive in scientific application at a definite place, to accomplish a definite objective.

If external or invading force overcomes internal resisting force, vertebral adjustment can be one of its resulting recoveries to the integrity of its osseous segments.

A vertebral adjustment is a re-establishment of a vertebra back to normal articulatory relations with co-respondents above and below; wherein it is untwisted, unkinked, unwrenched, untorqued in three directions; wherein it is "unlocked" so that internal health force will work co-ordinately with external force.

Internal force, in conjunction with correctly located, correctly directed external invasive force, is great enough to absorb a united action.

Vertebral adjustment—concussion of forces—permanently unlocks abnormal torqued subluxation.

Permanently torqued vertebral subluxation is permanently unlocked from its abnormal position.

Permanently unlocked abnormal position permanently opens occluded lumen thru which nerves pass.

Permanently opened lumen thru which nerves pass, permanently releases pressures upon nerves.

Permanently released pressures upon nerves, permanently restore normal transmission of mental impulse supply.

Permanent restoration of normal transmission of mental impulse supply returns normal quantity flow of internal, resisting, rebuilding health forces.

Permanent restoration of normal quantity of health force flow creates an accumulative constructive survival value, called health, stepping up to par the speed of action of motion of tissue cell structure.

Step by step, each normal cause produces normal effect.

EXTERNAL CAUSE was concussion of forces.

INTERNAL CAUSE is vertebral adjustment.

(Study more thoroly a full exposition of the Chiropractic Art in Chapter XII.)

"SUPERIOR," "INFERIOR," "HIGH," "LOW"

In attempting to put into words the wedge-side-slip subluxation of atlas, we found ourselves running into a conflict of dual use of certain anatomical terms that should be used, but could not be used without confusion.

In the wedge-side-slip atlas subluxation, the left or right lateral portions of atlas (A-P view) could be "superior" or "inferior." In describing the same subluxation (lateral view) same

thing could exist on anterior arch of atlas; it too could be "superior" or "inferior." The question was how to describe "inferior" (A-P view) with "superior" (lateral view).

To make a distinction, we changed terms, viz., for A-P views we spoke "high" or "low" and on lateral views we kept the terms "superior or "inferior." We hope this explanation will be remembered when you reach that portion of the book.

CHAPTER IV.

THE SPECIFIC

In the spring of 1930, the HOLE IN ONE movement began to take form. It was born in the mind of one man. He alone proclaimed it, believed it, practiced it. The more he practiced, the more he believed. The more he believed, the more he proclaimed. Others, believing him, listened to what he said. Gingerly, with fear and trepidation, they tried it out in a few cases. It worked. They added more. Soon a few were using it exclusively in their practices. The more THEY used, the more THEY believed. The more they believed, the more they proclaimed. The story was told others. Others began to think, believe, use, and proclaim. Today several thousands are using it competently. Other hundreds are trying it. Still more hundreds are learning it. None find it wanting, who are capable of correctly applying ALL its elements.

But there is one mind that is years ahead of all—that first mind that thought it first. As he creates, he develops; as he develops, he teaches; as he teaches, others try. It is now a snowball growing into huge proportions.

There is at our command positive proof of 5,000 field cases on which HOLE IN ONE system has been tried and found workable. All these cases got well from cervical major HIO adjustment alone.

(Chapter XLI, at rear of this book, is an ANALYSIS OF HIO SCIENTIFIC APPLICATION OF SPECIFIC CHIROPRACTIC IN 5,000 CASES.)

Let us ask! If these 5,000 cases get well from cervical adjustment alone, WHY is the major to be found ONLY in the superior cervical vertebrae? WHY are there no subluxations below? WHAT is peculiar, different, that makes a subluxation possible ONLY in the superior 3 cervical vertebrae? In what way, if any, is there anything different there, than is to be found anywhere else? WHAT exists in the superior 3 cervical vertebrae that makes some VITAL condition different there than is found in any other section of the spinal column? That thousands of all kinds of cases ARE getting well by exclusive adjustment, confined exclusively to this area, is strikingly present in our ranks.

WHY? The FACT is, in practice. WHAT THEN IS THE EXPLANATION OF FACT, IF IT IS KNOWN, IN THE CERVICAL REGION THAT MAKES THIS AREA WHAT IT IS?

In THE HOUR HAS ARRIVED (P. 9), we laid down the FIRST half of No. 3. Few deciphered. Few follow closely enough to know a NEW version when it appears. It suggested a solution for many unknown unsolved problems.

In brief (we suggest you reread the article): Subluxations of superior cervical vertebrae interfere with the ONWARD flow of mental impulse supply that could not get thru the interference. There was a BACKWARD pressure into the brain, from which it was issuing. The brain is the seat of generation of all human life forces. The brain makes as it needs. It needs as it uses. Its requirements are based on demand from the periphery as interpreted from the afferent half of the normal cycle which is never under pressure or interference, to meet the efferent needs of the body. Every second, minute, and hour there is energy created to supply all parts of the normal body. The brain is not a storage plant. It generates for present needs. When it manufactures and cannot get thru, there is congestion in the brain; or if there is normal adaptation and reduction in manufacture, there is an absent quantity in the body. The brain would thus represent a damming backward of supply and the brain in thinking value would be stalled with an excess of power that could not be used within itself. This affected the body below because of an ABSENCE of the normal quantity. The brain would become energy-clogged and the body energy-empty. Congest any part of the brain and you affect all parts of the body that should be fed by it. Any case which was suffering below for the want of energy, might at the same time be suffering above because of an excess of it.

CHIROPRACTIC TEXT BOOK, Vol. XIV, page 13, states: Art. 43. Innate Brain.

"That part of the brain used by Innate, as an organ, in which to assemble mental impulses.

"It is supplied with mental impulses directly from Innate Intelligence, whose headquarters it is.

"It is a vital spot and cannot be dis-eased.

"Its existence is actual, but its location is theoretical.

"There is no transmission of mental impulses from Innate Intelligence to Innate brain. There is no necessity, Innate being right here. For this reason, it always has 100% mental impulses. This being true, it has perfect function, perfect metabolism, and never has incoordination. It does not assimilate poisons from the serous stream. It is of course subject to trauma, the same as any other tissue. It must be supplied with nutriment and blood as any other tissue. A virulent poison can penetrate it. If it is injured by trauma; if it is subjected to anemia—lack of blood and nutriment; or is poisoned in spite of its resistance, then death ensues speedily, for it will not endure dis-ease or trauma. It must be remembered that although Innate's management is nothing short of miraculous, she is after all limited in what she can do because of the limitations of matter."

THE HOUR HAS ARRIVED, page 9, states:

"However, there is ONE phase that we have all been prone to almost overlook, viz., what happens to the brain. In the past, we have taken the position that the Innate brain cannot be affected and the Educated brain could be and often is in phases of insanity, which is subject to grades of variations of interpretations. But there remains one doubt which will be cleared up; what happens to the Innate brain when the body goes thru a process of auto-intoxication; internal poisoning? Let me make this clearer. The function flows from the Innate brain to the spinal cord, thru the spinal nerves, to the kidneys. A subluxation occurs along the path of this nerve, enroute, carrying function to the kidneys. The kidneys become paralyzed; inactive. Poisons are now dammed back into the body. All portions of the body become involved with an internal absorption of this internal poison. What right have we to presume that the Innate brain is exempt from absorbing some of this, the same as other parts of the physical body? If the Innate brain can and does absorb poison, where is IT to receive ITS source of power from, to rebuild itself? And, if it does become intoxicated, how can an intoxicated brain produce a healthy, normal supply of mental impulses to supply the body that needs them more at this time than any other? How is the kidney to receive a normal supply of healthy mental impulses when the subluxation below has been

corrected; when the brain that generates them is not normal within itself?

"Granting that Innate brain is the source of all mental energy, mental impulse supply for all the body; granting our majors are usually found close to the skull line as in the atlas or axis; granting this does occlude the lumen, produces pressure, constricts nerves, offers resistance and interference to transmission—might not this congest and congeal backward the onward flow of this thot-power intended for the body? Might not some of it work itself out as increased heat at the point of resistance; and yet rarely do we get a NCM No. 2 reading at this point that will rise much over 3 or 4 points. We do know that adjustments here get our gross number of cases well. Might it not be that there is a damming back of mental impulses, especially when it is close to its source of generation? And if this be a possible explanation, would this not directly affect the whole of the Innate brain more or less, and thus react indirectly upon many other parts of the body, though their nerves be free from interference to transmission below the point of exit in the spinal column? Might it not be that an adjustment at atlas or axis does more than release a spinal cord pressure, more than restore a normal transmission inferior to itself; might it not actually release a congestion superior to itself and thus clear all the Innate brain and thus clear all transmission below in many organs that otherwise would be sick? Might it not be that the actual local atlas or axis resistance might be low, and then the superior internal brain congealing or damming back might accentuate much brain interference which cannot be read, altho manifested below in many places, in many ways? These are questions which remain, as yet, unanswered directly. The future has many secrets to solve. That we are doing the thing, is obvious.

The INFERIOR meric system was developed first. For many years it was THE ONLY meric system we knew, had, or used. Later, a SUPERIOR meric system was developed. Our first series of observations was OF THE BODY. Later we realized that THE BRAIN was an essential extensional superior meric portion of the same inferior meric system.

The same comparison can be made for our study of dis-ease. At first it was a series of observations of symptoms, pathologies,

etc., as they were manifested IN THE BODY. It was the ONLY system we knew, had, or used. Later we began observations OF THE BRAIN for which we established what was termed "adaptative" mental interpretations of external physical conditions. NOW we are understanding that THE BRAIN is an essential superior extensional portion of the same inferior spinal system and can be DIRECTLY affected.

Dis-ease is now either:

- (a) superior brain congestion; or
- (b) inferior body starvation; or,

(c) some of both, all of which is brot about by an interference betwixt and between brain and body at a point where one ends and the other begins; brot about by odontoid process pressure upon spinal cord, damming back onward flow of mental impulse supply INTO brain which automatically interferes with onward flow of mental impulse supply INTO the body.

These two contradictory thots represent the difference in the development of our idea between 1927 and 1931 when each were developed. We now present the enlarged idea as of 1934.

CHAPTER V.

THE EXCLUSIVE PROCESS OF DEDUCTION



ONLY by the mental and physical process of exclusion can a fact be ascertained and proved; understood, and be known to exist. One who follows inclusive ideas, methods, or processes is never in any position to make any statement with competency, accuracy or with stability of any issue being proved true.

Suppose a sick person is given six different methods of treatment, each different from all others. Which method got him well, assuming he did get well? A STATEMENT can be made that a certain one did. What proof is there as to correctness of the statement? None! There are five methods to refute the statement.

Suppose a sick person be given five methods of treatment and one method of adjustment, each different from all others—which method got him well, assuming he did get well? A STATEMENT can be made that one of the five treatments, or the one method of adjustment succeeded. What proof is there as to correctness of this statement? None! There are five methods to refute the statement.

Suppose a sick person is given six different “techniques” of adjustment, each involving a different principle from the other five. Which technique or principle got him well, assuming he did get well? A STATEMENT can be made that a certain technique or principle got him well. What proof is there as to correctness of the statement? None! There are five techniques and principles to refute the one. These are INCLUSIVE methods or processes; and because they INCLUDE diluting elements, the finger of fact cannot be spotted upon ONE as THE successful item.

Suppose, on the reverse, a sick person be given ONLY ONE adjustment, at ONE place, in ONE way, to the exclusion of all other methods, techniques, or means; and the person got well. A STATEMENT can now be made that a certain technique or method, at a certain place in a certain way, DID get him well. What proof is there? Both INCLUSIVE as well as EXCLU-

SIVE. Only ONE was included; all others excluded. Having ascertained that one thing, done one way, attained one result; if duplicated time and again, it establishes a practice that proves a principle.

The average Chiropractor glibly rattles conclusions which are not justified. He uses inclusive mental and physical processes, and shouts exclusive mental and physical conclusions. In the average Chiropractor's office he uses antipodal principles and practices; opposing methods and techniques; varying them from time to time, more or less changing places from week to week or month to month and when his opinion is asked about merits or demerits of any one he uses, he rushes into print with an opinion not warranted.

Because of this inclusive process of thinking and acting, the average Chiropractor's opinion as to the merits or demerits of principles or practices is unreliable and unworthy of attention upon the part of any scientist who seeks truth or fact reached by the exclusive method.

Here is an occurrence between two chiropractors to prove the statement.

B is NOT a SPGH-NCM-HIO chiropractor. He has heard about it and desires to prove its merits or demerits. The principle sounds good but will it stand up in practice? He wants to set aside a number of cases, for one month, for that purpose. He wants A "to pick majors" after which B will adjust.

A IS a SPGH-NCM-HIO advocate. He is competent and efficient in using and interpreting spinographs. He knows how to use NCM on HIS cases in HIS office in DAILY use.

B asks A to "spinograph and read films; read B's cases with A's NCM." If A will pick majors in B's cases, then B will adjust and test HIO.

A consents.

B sends cases to A's laboratory. Spinographs of B's cases are taken A-P and lateral. They are interpreted and read, as of THE DAY B's CASES ARE IN A's OFFICES. A reads B's cases and locates WHEN AND WHERE interferences are ON THAT DAY. A tells B WHAT the listings are and WHERE readings are on B's cases; WHERE A would adjust IF they WERE A's

cases; but, says A, "I would adjust ONLY WHEN the NCM found a major reading of 2 FOINTS OR MORE."

B has cases call daily, semi-weekly or tri-weekly according to his office custom. He adjusts REGULARLY, ON EVERY CALL, ONLY ON MAJOR as listed by A, for one month. He watches and studies cases carefully. He has cases report how they feel, changes if any, etc. At end of 30 days, B reports to A: "I have given your HIO principle and practices a fair trial. A very few got better, many got worse, some remained the same. I am now convinced the HIO is not what it is purported to be. I had hoped that would come thru."

NCM gives information WHEN readings are and are not

- tells WHEN TO and WHEN NOT TO adjust.
- tells whether an adjustment HAS or HAS NOT been given.
- reveals whether an "adjustment WAS SUCH or was a push or shove.
- reveals whether subluxation was correctly seated or reversed to opposite direction.

WITHOUT NCM how did B know WHEN readings were or were not?

- how did B know WHEN TO and WHEN NOT TO adjust?
- how did B know whether adjustment WAS or WAS NOT given?
- how did B know whether he gave AN ADJUSTMENT or just another series of pushes or shoves?
- how did B know whether he permitted an adjustment to be correctly positioned or whether he shoved it into reverse, reversing pressures and interferences?
- how many times did B "adjust" when it should have been left alone?
- how frequently did he side-slip to opposite side and had no way of knowing that, therefore did not stop making his cases worse?
- how did B know when he had pressures off and then was the time to stop?

It was impossible for B to answer any question without he had used an NCM competently, efficiently and honestly. In "a very

few" cases accidents happened and "a very few" cases got well. In others, "many got worse" and they followed the rule of over-adjusting as they should. "Some remained the same" because he was NOT delivering an adjustment and did not know he was not.

B played with a workable demonstrable principle and practice, for 30 days, like a novice. HE NEVER ONCE, ON ONE CASE, COMPETENTLY, EFFICIENTLY, OR HONESTLY TRIED THE HIO. Yet he then considered himself competent and he now considers his experience sufficient to pass judgment in condemnation.

Essence of scientific thinking is questioning. It is by questioning that scientists seek truth. In true scientific spirit, we are loth to believe anything that has not been demonstrated. Science must question, faith cannot. As we become mature and suffer disillusionments of life we question more. It is one temptation of maturity to become over-skeptical and discard needlessly our cherished beliefs. Conclusions drawn from pseudo-scientific research, misinterpretations of announced results of true scientific research, and failure to discriminate between opinions and facts in science cause people to go astray in thinking and lead them to accept theories which, though seemingly in accord with modern science, are disturbing and perhaps fatal to old, cherished beliefs. We do not criticize a writer for stating his opinion, but when he arrogates to himself authority of science and states opinion as a scientific fact he deserves criticism. No man has a right to speak for science unless he knows whereof he speaks. Some speak or write for effect and would rather say something clever than true, rather be popular than right.

We suggest the following safe rules:

1. Discriminate between what is scientific opinion and what is a demonstrated scientific fact.
2. Discriminate between opinion of an individual scientist and consensus of opinion of scientists.
3. Discriminate between opinion of pseudo-scientists and that of real scientists; also between scientific opinion as reported by non-scientific writers or speakers and scientific opinion as expressed by scientists themselves.

4. Make allowance for possible changes or modifications in scientific opinion. The difference between scientific opinion and scientific fact is that former is subject to change whereas latter is not.

5. Beware of your own or another's misinterpretation of a scientific opinion or fact.

6. Do not mistake lack of evidence in support of a belief or theory as evidence against that belief or theory.

Here are some safe things to remember:

1. Limited power of average man to comprehend science.

2. Limited power of average man to observe science.

3. Limited capacity of average man to interpret what he observes.

4. Limited ability of average man to follow a line of reasoning until it proves itself right or wrong.

5. Limited ability of average man once he does reach a right or wrong conclusion to efficiently build himself and keep himself efficiently built to apply facts of science.

6. Science is slowly getting people to use the scientific method of thinking. To seek facts with an open mind to analyze and interpret facts; to let analysis lead where it may, regardless of personal preferences or prejudices.

7. Science is increasing our capacity to wonder. It helps us to discriminate between non-essentials and basic facts.

Practicing with HIO principle is like placing people on various steps of a stairs or locating them on various rungs of a ladder. With every flight or ladder, there is a bottom from whence they BEGAN and a top where they hope to arrive. There was a time when there were no HIO stairs or ladder. Occasionally there is a new TOP for we add steps and rungs. Each HIO practitioner will be found somewhere on a level of ascendancy between bottom and top. To hear any chiropractor say that he "uses HIO" may mean nothing, something, or much, according to understanding, mastery of its known elements and his attainment of efficiency in combining all into one completed harmonious whole and constantly keeping on keeping on increasing his efficiency in application without slipping. A certain chiropractor recently wrote: "I use HIO but I do not need nor do I use an NCM. I tell by palpation when to adjust." Obviously he wasn't with-

in seeing distance of the principle or practice of HIO. Caveat Emptor! Caveat Venditor!

There can be no unity with a superior complex. There can be unity with an inferior complex. Wise men create a superior complex. Ignorant men have no inferior complex. Wise men are the minority class. Ignorant men are the majority mass. This explains existing split between minority class and majority mass professional differences. The majority of chiropractors belong to the mass therefore do not suffer with a superiority complex. They can agree and usually do. You cannot use scientific methods in an unscientific manner and expect scientific results.

The average Chiropractor is a practitioner, not a scientist. He has a living to make. He feels he cannot afford "to take chances" on failing to get a case well; so he includes all his conscience permits (which is usually quite elastic where dollars are concerned) "so he cannot fail." Under this all-inclusive process ACCIDENTALLY and OCCASIONALLY a sick person gets well. He has no means of knowing which system or technique; which place or manner of adjustment achieved the result. He would rarely duplicate the result on another case, exactly alike, if he were to receive such. It is the ACCIDENTS, OCCASIONALLY, that have been a means of sustaining his business. Sick people got well ACCIDENTALLY and OCCASIONALLY enough to let the minority overshadow the large majority on which he failed.

Research means what it implies; the research worker separates out failure elements and eliminates them; separates out success elements and retains them; constantly accumulating elements by the exclusive process until that day arrives when he can definitely make a positive assertion of fact; prove it, and duplicate it.

That sick people have always gotten well, in ancient days, as well as modern, from superstition to science; internal as well as external methods; by mental faith as well as physical drugs, there is no doubt. That sick people go to Chiropractors of varying shades of belief in Chiropractic; with different techniques, adjustments, methods and means, and OCCASIONALLY and ACCIDENTALLY get well, there is also no doubt. That sick people go to Chiropractors who punched them all up and down the back

and got them well, using varying methods of racking, stretching, jerking, and pushing back-bones, from head to tail-bone, and got some of them OCCASIONALLY AND ACCIDENTALLY well, we admit is true.

I affirm it IS possible to do something at any, many, or all vertebrae below occiput, atlas, or axis from which results have been or can be indirectly, accidentally and occasionally attained which, in results, seem akin to those which we have attained by adjusting directly upon the specific atlas or axis subluxation. I reaffirm that no amount of "adjusting" upon any, many, or all vertebrae below occiput, atlas, or axis, could or would directly ADJUST THE SPECIFIC three-direction torqued subluxation causing any, many, or all sickness in a body. These statements seem contradictory. How can they square themselves? If atlas or axis IS the only possible three-direction torqued subluxation in a spinal column, causing any, many, or all dis-ease in the body, how and why does something done at some distant or remote place get case well, affirming again that such HAS occurred? That few cases have been adjusted EXCLUSIVELY below; or adjusted below WITHOUT addition of cervical vertebrae above, is beside this issue. We hypothecate the improbable that it might exist altho never proved.

If case was "adjusted" 6 places; 5 were not subluxations, 1 was, which were INDIRECT, which DIRECT? Which one got case well? If case was "adjusted" 5 places below, none of which were subluxations, and case got well, HOW did case get well when 5 INDIRECT places were "adjusted" and DIRECT subluxation was ignored? If case was ADJUSTED one place and it WAS THE DIRECT SUBLUXATION and case got well, WHY did he get well when 5 INDIRECT places were ignored? If all three cases got well, was there difference in quickness of return to health; a difference in reason established? If so, WHAT WAS THAT REASON?

Suppose one chiropractor "adjusted" 6 vertebral meric system locations daily for 3 months, and case got well, is he in a position to affirm that the meric system IS BETTER than if same case had gone to a competent HIO user, was adjusted 1 place, 3 times and got well in one month? A few chiropractors today express opinions regarding merits or demerits of HIO based on experi-

ences with cases only under meric system. One who has sincerely and competently tested both methods and comparatively checked both by contrast, can make a fair denial of one and affirmation of other.

Subluxations ARE CAUSED by concussions of forces. It is NOT necessary that concussions of forces occur DIRECT upon occiput, atlas, or axis to produce an atlas or axis three-direction torqued subluxation. A person might stub his toe, fall on sidewalk, fall off a building, sit on buttocks; a friend might slap another between shoulders—any of which could be the distant or remote point of entrance of a concussion of force and produce a major specific three-direction subluxation of atlas or axis. The head or superior cervical region might get direct effect of blow and produce same condition, same place. Force may enter any place in a human body, travel from point of entrance to place of least resistance; where vertebrae are not subject to restriction of locks; where it is least able to absorb, correct itself, or resist; where possibility of production of a three-direction torque could be created; where weakness is its greatest potential damaging factor; where less force could produce a three-direction torque, create interference, and create dis-ease. An external force might have entrance at hips, produce fractured coccyx, misaligned lumbar vertebra; travel upwards, produce torqued axis, and create dis-ease. Specific, major, torqued subluxations are CAUSED by concussions of forces that ENTER THE BODY ANY PLACE, BUT TRAVEL TO PLACE WHERE THEY CAN DO DAMAGE. No entrance of force in lumbar, dorsal, or lower cervical could do damage locally except as minor misalignments.

(See Chapter VIII, under heading "A Vertebral Subluxation Must Have Three Directions," for reasons why any vertebra below atlas or axis MAY BE misaligned but CANNOT BE subluxated.)

The same entrance of force below CAN produce a subluxation at atlas or axis. The place of entrance of force does not determine the location of final arrival of force in creation of subluxation; therefore dis-ease creating damage.

There exist paradoxes in our Chiropractic group-mind which understands that vertebral subluxations are PRODuced by introduction of accidental external force in concussion of forces. They understand that an external accidental concussion of force can enter anywhere AND TRAVEL from where it enters (which is

anywhere in a body) to where it PROduces vertebral subluxation. Paradoxically they hold that when THEY intentionally introduce an external concussion of force to REDuce a subluxation, it is a dud and stops dead at place where they enter it, after attempting to "adjust" THAT vertebra. He believes when HE delivers a force ON "a vertebral subluxation" (anywhere below axis) that it enters, stops dead. Therein IS the paradox. Forces DO travel whether they come accidental after a fall, or whether he introduces them by intention. He knows they travel in PROduction, but thinks they do NOT TRAVEL when he introduces them for REDuction. HIS force can and does travel from place of introduction (anywhere below axis), where it may do good OR harm, TO a place where it might do harm OR good. ALL external forces, introduced below axis, cannot do harm or good AT THAT POINT because the delivered force meets osseous articulatory locks where it cannot lock or unlock any articulation in three necessary directions to create a subluxation; but it CAN travel to where there ARE NO locks and CAN unlock a major vertebra and torque it into a three-directioned subluxation. The same principle applies as to adjustments upon atlas or axis, there being no locks, it can be corrected, when subluxated, if forces are correctly applied WHERE vertebrae CAN be moved minus articulatory locks which might otherwise prevent.

A case in point: man fell off scaffold. Struck scantling on back across 12th dorsal. Fracture dislocation occurred. His backbone was in angular acute kyphosis. He was paralyzed from 12th dorsal down. HIO Chiropractor found no interference readings at 12th dorsal. He did find a major, specific, torqued interference subluxation at axis. HE ADJUSTED AXIS. Case got well of paralysis. Fracture and dislocation continued.

The more remote entrance the concussion of force, the greater that force must be to PROduce or REDuce a subluxation where it CAN BE produced or reduced. It would take less force direct upon atlas or axis than in lower cervical region; more in dorsal than in lower cervical; more in lower dorsal than in superior dorsal; more in lumbar than in lower dorsal; more on buttocks than in lumbar. Hence the farther removed, the greater increase of quantity force necessary in ratio. Forces spend themselves as they travel, before they arrive. If a force enters at hips and

produces a subluxation at atlas or axis, much was dissipated and absorbed between hips and atlas or axis. The more remote entrance of a concussion of force, as distant from atlas or axis where a subluxation can occur, the greater potential it possesses for doing wrong in PROducing a subluxation and the less potential it possesses for doing right in REDucing a subluxation.

The probable degree of damage done by a concussion of forces is measured by distance a known force travels, spends, and is dissipated between the place of entrance and final disposition of expenditure; as well as by degree of concussion of forces that actuates moving of normal bodies into abnormal positions. It would take less force to create misalignment than subluxation; less for subluxation than dislocation; less for dislocation than fracture. Reversing the analogy, it would take more force to create fracture than dislocation; more for dislocation than subluxation; more for subluxation than misalignment.

The more direct entrance the concussion of force, the less force must be expended to produce (if delivered wrong) or reduce (if delivered right) upon part of a Chiropractor. It would take less force upon atlas or axis direct, to create or correct a subluxation, than in lower cervical region. As we increase distance of body mass away from, we must increase quantity of force, to either increase or decrease its damage or good attained. The more direct entrance the concussion of force, the greater potential it possesses for doing right in reducing a subluxation and less potential it possesses for doing wrong in producing a subluxation.

Remote adjusting is like trying to give a direct adjustment at a distance. Out of multiple attempts made, at places other than where subluxation is, each of which is problematical, accidental good or accidental harm is liable. The Chiropractor attempting "adjustment" at a place where no subluxation exists, (below axis) has no conception whether force below will arrive far enough up; whether if it arrives it will make subluxation worse or better; whether it stops part way and never arrives at a possible objective if it did arrive; or whether it was a dud along the line somewhere between. Out of multiple attempts made, at places other than where subluxation is, now and then SOME good MIGHT happen; a subluxation MIGHT indirectly happen to be adjusted; subluxations MIGHT be increased, and

the balance attempts MIGHT fall on barren soil, could be lost effort and wasted time upon part of Chiropractor as well as patient. It is that small, narrow margin of accidents which DID occasionally happen thru the years, which DID convince a sufficient minority of cases, Chiropractors, that a subluxation could and had been adjusted, that kept Chiropractic alive. Between remote control occasional and accidental adjustment, and the direct without-knowing-it adjustment on major specific, a percentage of cases HAVE BEEN GETTING WELL of many diseases which have justified Chiropractors believing there WAS something to the Chiropractic principle.

The town of Bingham, Utah, lies down in a crotch between two precipitous hills. On one hill is a copper mine. I stood on the opposite hill, at noon one day. I was feeling fine, physically and mentally. At noon they blasted tons of gun-powder. The reverberations were so great that I came away with a headache. A concussion of forces, REMOTELY LOCATED, had accidentally created an atlas subluxation. Now that a subluxation HAD been produced, the probability is that it would become permanent and I would be a chronic sufferer from "head-aches," and eventually other worse conditions would follow in its wake. Where these forces ENTERED my body, I was never able to determine. If theory of "remote control adjusting" be sound, it would be serious if the only place I could get this subluxation "adjusted" would be to return to the seat of its origin (Bingham, Utah) and the only way it could be REDuced would be to secure REverse of its cause in same remote control manner, viz., go back to that valley, from day to day, have those powerful gun-powder reverberations bombard my body, with hope that SOME DAY IN SOME WAY, accidentally, they MIGHT REDuce it so I could get well. I would not think of returning to that opposite hill at noon, day after day, with the hope that another series of remote gunpowder reverberations MIGHT accidentally REDUCE that subluxation and "cure" my headache. Preferably I went to a Chiropractor; had him ACCURATELY LOCATE THE INTERFERENCE, prove its position, and had him DIRECTLY adjust it. It took much less force upon his part, upon atlas, to REDuce it than it did upon the part of tons of violent explosions, remotely located, to PROduce it. Result—subluxation directly, scien-

tifically, intentionally, and designedly reduced—headaches gone.

Yodelers are not permitted to yodel from mountain-tops or in valleys in Switzerland, in the spring of the year. Altho distantly removed, perhaps miles, voice vibrations loosen snow-slides, avalanches which have been known to bury cities and people. Vibration, at a distance, loosens the mountain of snow, located thousands of feet higher across valleys or on mountain-tops. What the yodeler did was remote from place affected. Had he been on mountain-top on the snow-pile, his feet, a crow-bar, or gun-powder could have directly done the same thing.

In Alaska, we approached the nose of Taku Glacier, 500 feet high, $1\frac{1}{2}$ miles wide, which extended itself into the ocean. Steam-ship approached within one-half mile. Whistle was blown. That vibration reverberated sufficiently strong, between boat and glacier to loosen mountains of ice which came roaring down into ocean. One stick of gun-powder placed on top would loosen a thousand times more, more easily, and do it directly.

As sublaxations can be and ARE sometimes produced by remote control, so can inefficient, incompetent, inaccurate "adjustments" be given by remote control. Any movement made anywhere along the spine, in any manner which introduces one of a concussion of forces, without discrimination, will travel upward and affect the neck, either for good or bad. Concussions of forces introduced anywhere in spine, by and thru medium of accidents, can and do occasionally and destructively produce sublaxations regardless of whether that force was introduced on bottom of feet, at coccyx, sacrum, lumbar, or dorsal vertebrae. Concussions of forces can also, when introduced anywhere in spine, by and thru medium of hands of Chiropractor, occasionally and accidentally constructively reduce sublaxations regardless of whether that force was introduced at bottom of feet, stretching of legs, straightening tilted pelves, at coccyx, sacrum, lumbar, or dorsal vertebrae.

A few years back, I read an account of a man who, while horse-back riding, struck his forehead against a low-hanging branch. He was picked up paralyzed. I read another account of a paralyzed man who dragged himself from bed to head of stairs, slipped, and fell to the bottom. He was unconscious. Rested a while, and walked off normal. Desiring to ascertain if "acci-

dents" only occasionally or frequently PRO-duced and RE-duced subluxations, getting well people sick and sick people well, I engaged a press-clipping bureau to collect all such from newspapers and magazines of America. They ran into thousands, every month. I kept it up three years.

When an "accident" HAPPENS to make a well man sick or make a sick man well, then that "accident" did something, somewhere, some way, that caused a living, feeling, actuating, human activating principle to change from normal to abnormal, and in practice to change health to sickness; and its reverse to change abnormal to normal, and in practice to change sickness to health. "Accidents" that change health to sickness or sickness to health, occur in the dark, under cover, hidden, concealed. It becomes an interesting mystery because a change occurs without human beings knowing where or how; the locality of entrance of change either way is unknown. That hundreds of thousands of well people have gotten sick by being kicked by a horse, or hit on the head by a falling brick, or in a thousand other ways, is interesting, but it isn't scientific. That other hundreds of thousands of sick people have gotten well by being thrown out of an automobile, or by slipping on a slippery sidewalk and taking a fall, or in a thousand other ways, is interesting, but it isn't scientific. I have the manuscript of a book prepared years ago, ready for printing, on the interesting information revealed by those thousands of clippings. It will not be published. It revealed nothing upon which to improve a service to mankind. That hundreds of thousands of sick people have gotten worse, OR BETTER, by being poked, punched, jabbed, at various sections of the human back-bone, by men who call themselves Chiropractors, who make a business of punching vertebrae of sick people all up and down the spinal column, without knowing where and why, and have caused accidental subluxations to be accidentally corrected occasionally, is interesting; but it isn't scientific. It is not correlated positive information. It has ever been a constant desire that some day I COULD KNOW AND BE ABLE TO TEACH A SCIENCE MORE EXACTING IN ITS PRINCIPLE AND PRACTICE than to duplicate falling bricks, falls down stairs, hits on heads, and slips on sidewalks. My ideal for CHIROPRACTIC was that we needed to KNOW the principle by KNOWING where,

why, and how these changes occurred, and to possess an art that could and would apply itself at THE right place, right time, right way.

An analysis of these clippings showed thousands of ways by means of which concussions of forces DID enter the healthy body, produced subluxations, and made well people sick. It also proved thousands of ways by means of which concussions of forces DID enter the sick body, corrected subluxations, and got sick people well. It was nothing new. It has been repeating itself for thousands of years on millions of bodies, even in our profession. It happens accidentally and occasionally, with similar spasmodic regularity, with Chiropractors. They approach sick bodies to get them well, apply a concussion of force at wrong place, and may REDUCE or PRODUCE a subluxation. I am NOT interested in proving or disproving that concussion of forces can be wrongfully applied, at wrong places, and get sick people well. I AM vitally concerned in proving that concussions of forces RIGHTFULLY applied, at RIGHT places; with knowledge, intention, and direction will accurately, efficiently, competently and honestly render that kind of a scientific health service which will get MORE sick people well QUICKER than any accidental or occasional method.

I am affirming that cases have gotten well, occasionally and accidentally, by work done at places other than upon specific, major, torqued subluxation of atlas and axis. Remote control has produced and can reduce subluxations. I am also affirming that more cases have gotten well quicker and remained more permanently, WHEN ADJUSTMENTS WERE GIVEN BY INTENTION AND DESIGN, at right location, in right direction, at right times, where given directly upon specific, major, torqued subluxation of atlas or axis.

To affirm that cases have gotten well by working on back below subluxation, does not confirm that it is right, best, quickest or attains the greatest percentage of results; neither does it deny correctness of correct work done at correct place, viz.: atlas or axis. To affirm that correct work done at correct place, at correct times, in correct ways at atlas or axis asserting that it is the better way, quickest and attains the greatest percentage of results, does not deny the bare possibility of occasionally and

accidentally doing the same thing at some remote or distant place.

Somewhere through this mysterious maze, there IS a principle and practice that DOES work and can be deciphered; brought to the surface and proved to be THE exclusive principle and practice by means of which the result IS attained. Whatever this principle and practice is, no matter how deeply hidden behind the curtain of mystery (even though it OCCASIONALLY and ACCIDENTALLY works) it CAN BE found, known, understood, and used EXCLUSIVELY and then made to work knowingly, constantly, specifically in all cases alike.

If people are well and get sick, it is because of the violation of ONE certain principle and practice. If sick people get well, it is because of a correction of that violation of ONE certain principle and practice. A cancer is a cancer in the body of one who has it, regardless of what they think, say, do, or believe as regards religions, methods, or systems of treatment of that cancer. If a cancer gets well in the body of one who has it, it gets well of cancer regardless of what the person thinks, says, does, or believes as regards religions, methods, or systems of treatment of that cancer. If a patient had paralysis and went to 100 different Chiropractors and each described a different reason for his getting paralysis, the fact would still remain that the patient having paralysis, had violated ONE principle in his body that caused it. If a patient having paralysis went to 100 different Chiropractors and each used a different technique, system, or method; and each succeeded in getting him well, the fact would still remain that only ONE principle and practice succeeded in getting him well. Somewhere hidden in every body is A SINGLE PRINCIPLE AND PRACTICE that works, either as a cause or as a correction. To seek THAT principle and be able to APPLY that principle is the ultimate objective of the research seeker and to solve that human enigma can be attained only by the exclusive process of trying them all, each by each, in individual form, and watching the net result.

Admitting that all methods get some sick people well; admitting that all methods interpret a different principle and apply a different method, there IS A QUESTION OF PERCENTAGE of accidents in the use of and application of THE principle and prac-

tice even tho more or less crudely and awkwardly applied, that works, even tho unknown. If the true reason why a FEW succeed in getting well, could be separated from the maze of accidental work done; and what was occasionally used that brought about that result could be eliminated from the chaff, certain things must stand out to prove a principle of a certain and definite character, located at a certain place. If the true reason why THE MANY failed to get well could be separated from the maze of work done; and what was used that failed to bring about that result could be accumulated, certain things must stand out to prove that certain other principles of uncertain and indefinite character, located at certain places, did not work.

WHEN IS A SUBLUXATION?

A vertebral subluxation is any vertebra out of normal alignment, out of apposition to its co-respondents above and below, wherein it does occlude a foramen, either spinal or intervertebral, which does produce pressures upon nerves, thereby interfering and interrupting the normal quantity flow of mental impulse supply between brain and body and thus becomes THE CAUSE of all dis-ease.

A vertebral subluxation IS a vertebral subluxation whenever it IS what is stated above, ALL elements being present. It is not such when ANY ONE ELEMENT IS ABSENT. It is NOT a subluxation unless the interference to transmission is present. There can be no pressure upon nerves unless the size, shape, diameter, or circumference of the foramen is changed. There can be no change in the normal size, shape, diameter, or circumference of the foramen unless one vertebra is subluxated between its co-respondents above and below.

(See further discussion of this subject under Chapter VIII, under title "A Vertebral Subluxation Must Have Three Directions.")

Up till the spring of 1930, it was generally believed and accepted as good practice that ONCE a subluxation existed, it had to be "adjusted" daily, regularly, constantly, and continuously for months, until the patient was well. Since the spring of 1930, we have consistently disproved this assertion, that it was NOT necessary to keep continuously and consistently hammering away at a subluxation to ADJUST it to normal position to ac-

comply with the objective elements, opposite those of a subluxation. Until the fall of 1932, it was generally believed that ONCE a vertebral subluxation existed IT WAS ALWAYS PRESENT DURING A 24-HOUR PERIOD UNTIL ADJUSTED. We have found, consistently, that oftentimes ONE "adjustment" constituted AN ADJUSTMENT in fact; that continuous repetition thereafter, thereupon, was injurious to the health welfare of the case.

A SUBLUXATION IS NOT NECESSARILY CONTINUOUSLY PRESENT 24 HOURS A DAY, DAY AFTER DAY, MONTH AFTER MONTH, or YEAR AFTER YEAR. Vertebral subluxations are not consistently or continuously existing before ANY adjustment is given. It may exist at times and for periods of varying length and not be present at others, which periods and length of time might vary considerably. It may exist 4 days of 24 hours each, continuously, of a week. It may exist 14 hours a day, continuously, of a possible 24. It may exist 18 days, continuously, of a month. These periods of 4 days of a week; 14 hours of 24; 18 days of a month, may be continuous periods or they may be broken into fluctuating, intermittent, or spasmodic spaces of time.

Examples: the period of 4 days of a week might be Monday, Tuesday, Wednesday, and Thursday; or it might be Sunday, Tuesday, Thursday, and Saturday.

The period of 14 hours of 24 might be from 8:00 A.M. to 10:00 P.M., or it might be every other hour; or in groups of 4 hours each, etc. (There is no way I know now of exactly determining the varying factors.) The period of 18 days of a month might occur every other day, or in groups of 3 days at a time, or they might be continuous.

Adaptative movements of head, in abnormal forced positions, to relieve pain, can temporarily obliterate subluxation, fade out pressure, and momentarily cease suffering—all the time the subluxation WAS present in reality.

(In this relation, study carefully text explaining illustrations 50 to 55, under "Care in Establishing Facts," Chapter VIII.)

This much is certain: IF THE DAMAGING EFFECT OF A CONTINUOUS MULTIPLE AND ACCUMULATIVE INTERFERENCE IS PRESENT MORE OF THE TIME THAN INNATE INTELLIGENCE IS ABLE TO ADAPT NORMALLY TO

OR IS ABLE TO REBUILD AND CORRECT, then there IS an accumulative DESTRUCTIVE survival value and dis-ease is on the growth. IF ADJUSTMENT IS GIVEN AND THE VERTEBRAL SUBLUXATION REMAINS ABSENT TO WHERE THE EFFECT IS A CONTINUOUS MULTIPLE AND ACCUMULATIVE RESTORATION OF INNATE INTELLIGENCE MENTAL IMPULSE SUPPLY AND IS ABLE TO ADAPT AND REBUILD, then there IS an accumulative CONSTRUCTIVE survival value. In either case, whether the case is growing better or worse depends upon HOW MUCH OF THE TIME THE VERTEBRAL SUBLUXATION IS PRESENT OR ABSENT, whether it be a minority or majority of the time, and whether bad works faster per hour than good can repair or balance per same time involved.

We know that fevers, as a type of dis-ease fundamental in character, have a rise in temperature beginning usually at or about 4:00 P.M.; reach their peak at or about 8:00 P.M., and reach a sub-normal ebb at or about midnight. The case again gets a similar rise at or about 4:00 A.M., reaching its peak at or about 8:00 A.M., and ebbs at or about mid-noon. As CAUSE, so goes EFFECT. As EFFECT, so IS cause. SUBLUXATIONS RISE AND FALL, in periodicity, as regularly as do observed symptoms.

In approaching this problem of periodicity of dis-ease, we can work from either of two ends. We can offer the solution that as end-organs DEMAND, so does the brain aim and try TO SUPPLY. As supply is shut off, so demand cannot be supplied. Doesn't demand, exceeded by supply, create an increased feverish activity which gives a rise in temperature, by backing up on the forward flowing current? Or, by creating a demand, via the cycle, can't we demand more at tissue cell than brain cell can get thru the subluxation? Can tissue cell ever demand more than normal? Will brain cell attempt to send more than normal? Can more than normal get thru the subluxation? If what gets thru subluxation is less than normal, and tissue cell expresses less than normal, and brain cell sends down normal, and subluxation lets less than normal thru, how can demand and supply back up and increase the NCM reading at place of interference? And where is demand and supply; is it at and in tissue cell, or is it

at and in brain cell? Who knows what supply is or why there should be a demand? What is demand and supply? Is there ever ANY demand and supply at tissue cell; or is all demand and supply a mental recognition of absent quantity at tissue cell and is not all supply a mental understanding at and in brain, based upon interpretation of quantity of function that is or is not expressed at tissue cell?

To argue that Innate reverses herself is an attempt to explain symptoms by symptoms from the symptom approach of dis-ease. We can offer the other solution that brain-organ stands ready at all times to supply any and all NORMAL demands made upon any and all parts of its body, providing supply can get thru to perform function. As supply is shut off, BY A CAUSE, so demand cannot get thru to perform itself. Thus ANY rise in temperature is created because of an INCREASED INTERFERENCE TO POSSIBLE TRANSMISSION. This explanation works from CAUSE TO EFFECT. The former explanation attempts to explain how symptoms, because of symptoms, work from one effect to another. Vertebral subluxations rise and fall, in periodicity, in degrees, exactly as do observed symptoms which are their effect. If heat rises as subluxation was increased, fever rises. If interference increases, fever rises. As subluxation "subsides," fever is lowered. Intensity of mean-line heat reading as well as marked quantity and quality of nerve-pressure heat-interference reading is a graph which can be measured as accurately as a fever chart kept of the rise and fall of fever as taken by a clinical thermometer taken by a nurse of same case. WE CAN NOW, FOR FIRST TIME, SCIENTIFICALLY ACCOUNT FOR PERIODICITY OF DIS-EASE, with a proof of irregular periodicity of its vertebral subluxation cause.

Innate brain, as source, is always a 100% quantity; ready, willing to meet any normal demand upon its body. At other end in tissue cell is a constant functional necessity, demanding a 100% supply. If there are NO interferences, normal supply will equal normal demand; and normal demand will be met by normal supply. But things are NOT equal in dealing with the problem of sickness and health. Between Innate brain and Innate body is a vertebral subluxation producing dis-ease. THIS SUBLUXATION PRE-DETERMINES QUANTITY OF SUPPLY THAT

CAN GET THRU TO MEET ITS OWN DEMAND. Subluxation is at all times THE REGULATOR OF UNNATURAL AND ABNORMAL SUPPLY TO MEET UNNATURAL AND ABNORMAL DEMAND. If subluxation is 1%, then there is a 1% occlusion, a 1% pressure, a 1% interference, and a 1% unbalanced supply. Demand may be 100%, but supply will be hindered TO THE EXTENT OF SUBLUXATION. So we can step-up or step-down varying degrees of subluxations which interfere with balancing of flow of law of demand and supply in tissue cell. SUBLUXATION AS CAUSE ALWAYS DETERMINES EFFECT, AS EFFECTS, AT TISSUE CELL. Subluxation limits law of demand and supply. Law of demand and supply in tissue cell NEVER effects degree of subluxation.

In exact ratio as subluxation exists, in degrees, so does its occlusion; its pressure; its interference; its heat readings as determined by the NCM. Quantity of nerve-interference nerve-pressure break heat reading IS DETERMINED BY DEGREE OF SUBLUXATION and is not determined in any sense by presence or absence of any effects at peripheral end of nerve which is purely an effect. EFFECTS DO NOT PREDETERMINE CAUSE, BUT CAUSE ALWAYS PREDETERMINE EFFECT. As subluxation varies, up and down its scale, within its range of possibilities, so does effect run up and down its scale in law of demand and supply. To assert that law of demand and supply, existing in an end-organ, reverses itself and backs up to and creates, increases, or decreases heat reading, is to affirm an old medical principle that effects create causes internally within ourselves. This is not Chiropractic!

Hypothecate a case of prolapse of stomach. In this case a subluxation is producing pressure, interfering with normal supply of stomach, hence dis-ease. There IS a demand from stomach for a normal 100% mental impulse supply. Some of it is getting thru. If it were all getting thru, stomach would not be prolapsed. Here is an example of stomach, end-organ, peripheral conditions, mentally defined, as demand and supply. As a result of vertebral subluxation, we have occlusion, pressure, interference and heat reading, quantity of which IS DETERMINED BY DEGREE OF ALL THESE ELEMENTS AT PLACE OF SUBLUXATION. Were this not so, all Chiropractic, as a principle or practice, would

be fundamentally wrong. Quantity of heat reading at subluxation is not determined by conditions which justify a demand and lack of supply to and in stomach. Quantity of heat reading at subluxation is determined by degree of subluxation with its pressure and interference.

Obviously, backing up, there does come a time when we must concede that there are fundamentally TWO laws of demand and supply; one external, the other internal. A man walks along street. He slips, internally. He meets the sidewalk, externally. Here is an EXTERNAL AND INTERNAL law of demand and supply. As a result, concussion of forces, shock, demand internally which he cannot meet externally, or a demand externally which he cannot supply internally. The net result—a vertebral subluxation. As a result, we get squarely into the question of law of INTERNAL demand and supply, for existing between is vertebral subluxation which fore-closes impossibility of internal supply meeting internal demand.

To affirm that internal demands which cannot be met within themselves, back up to and affect vertebral subluxation, pressure, interference heat reading, is to affirm a long-known, well-established principle of medicine. To affirm that internal tissue cell demand which cannot be met, is caused by vertebral subluxation, which never does and cannot back up efferently on itself as a cause, is to affirm a long-known, well-established principle of Chiropractic.

HIO research clinical workers have read cases and observed vertebral subluxations at various times of day. At some hours, some days, interference reading IS present. Same case, tomorrow, same hour, may have no reading at all. We may have another case that will register certain readings at certain places at certain times of day, regularly; but none to be found at any other hour of day. Other cases will record certain readings at certain places almost regularly, except as to varying degrees; but none to be found at any other hour of day. Other cases will record readings at some places regularly at any hour of day, or day of week; while certain other readings may or may not be present at varying hours or days. Thus A VERTEBRAL SUBLUXATION IS NOT ALWAYS A VERTEBRAL SUBLUXA-

TION AT ALL HOURS OR DAYS, PERMANENTLY AND CONSISTENTLY.

This conclusion of fact can be deduced only where (a) case after case has been given a regularity of reading covering long periods of observations; (b) where case after case has been carefully, accurately checked, and a continuous record made; (c) where cases are checked regularly at same approximate time of day thruout entire period of observation. Obviously this conclusion of fact could not be deduced if (a) cases were observed for a few days or two or three weeks; (b) where no records are ever made and entire matter is a matter of memory; (c) where cases would be checked at convenience of case which might be morning one day, and evening the next, thus changing elements which could reliably account for all variances. One peculiarity about observing cases is that no two present common conditions of study. After checking this observation for over 10 years, I have been unable to deduce any LAW that remains fixed to all alike on the question.

Obviously, it is decidedly vital TO READ CASE WHEN SUBLUXATION IS PRESENT. If we knew exactly WHEN it WOULD appear, as to its hour or day, its length or shortness of stay, we could and would advise case to come DURING ITS EXISTENCE; check it, and adjust it out. But no two cases run true to any law. In any one day it might be at a certain hour. On next day, it might be at very other end of the day.

One type of case in which this manifestation comes clearly to the fore is epilepsy. I have studied this type particularly because it proves INTERFERENCE CLEARLY, although observations are also possible on many other types with as marked clarity; altho in many chronic types it does not make it possible to be observed at all.

A case of epilepsy will come for days or weeks with daily checks, and no interferences showing. Suddenly subluxation slips into picture, interference occurs, and a seizure is on. If a Chiropractor could read this case within a reasonable time BEFORE or shortly AFTER seizure, interference will be plainly marked and easily found. An adjustment GIVEN THEN will correct it to normal position where it may remain for an indefinite period again, assuming it is given in right way, at time of

existence, at right place. A further observation shows that if this then-existing subluxation is NOT adjusted when it exists, it will gradually fade out of picture and remain away an indefinite period of time. BUT IF LEFT ALONE, AND NEVER ADJUSTED, IT WILL GRADUALLY KEEP STEALING UPON THE GAPS THAT INTERMITTINGLY EXIST UNTIL IT KEEPS OCCURRING MORE FREQUENTLY AND EVENTUALLY WILL SHORTEN THOSE GAPS BETWEEN UNTIL SEIZURES COME FREQUENTLY AND MORE IN DEGREE.

The idea that ONCE A VERTEBRAL SUBLUXATION, it exists 24 hours a day, must now give way to the newer fact observation that all that is necessary to reduce the health of an individual is that it be more or less present more or less of the time which gradually decreases distance of time between which decreases health time periods and increases dis-ease time periods, effects of which increase in severity or in periods of time and reduce resistance of tone of tissue structure and thus introduce its opposite of dis-ease of tissue function.

We could and can very materially step-up our efficiency in taking cases and getting them well quicker IF WE COULD HAVE A CASE UNDER OBSERVATION EACH HOUR OF THE 24-HOUR DAY, EVERY DAY OF WEEK; MAKE AN HOURLY READING AND ADJUST IT ONLY AT SUCH TIMES AS IT DOES APPEAR, which more than likely would make adjustments MORE FREQUENT, ON THE MAJOR, than occur now under one-a-day reading system now in vogue. As it now stands, our case appears ONCE each day. At that particular hour IT MAY NOT BE PRESENT. It might appear at some other hour of same day. Coming at a stated daily hour, finding no reading, no adjustment is given that day and any accumulative constructive survival value we might render THAT DAY is NOT rendered because we were NOT present when vertebral subluxation DID appear. Our case appears daily, and for several days or weeks subluxation may stay out, but sometime during some day IT DOES appear. If we are fortunate in making our reading on day and at hour when it is either coming in or going out, we can and will render service of tremendous value far beyond our wildest dreams.

Our nonscientific friends, taking advantage of this scientific

known weakness, would say: "To be positive, sure, and get subluxation adjusted, we would adjust ALL vertebrae, whether subluxated or not; whether creating interference or not; thereby missing none if one existed, regardless of time of day, whether it was or was not present when case called into our office." The hazardous evils in such situations far overshadow the good. 23 vertebrae do not need adjustment because they are not subluxated, therefore any work done upon them could create, not relieve, interference, 23 times where they might accidentally release one subluxation IF it happened to be existent at that time. If they accidentally stumbled onto subluxation at time when it WAS present, then some good MIGHT be done IF they adjusted it right direction at right location; but meanwhile they would be doing 23 times as much wrong in 23 places that needed no attention. It is better to wait until you KNOW, are CERTAIN, possess positive information and scientific data, and then do what needs be done, where and when it needs it, than to do many things wrong, at wrong times and places.

By having our case come daily, at an appointed hour, which hour has a regularity value, we are rendering competent POTENTIAL value much greater than at any other period of our history; but if we could have an hourly check, day by day, we could AND WOULD soon build up a chart record which would give us more exacting data TO KNOW WHEN SUBLUXATION APPEARS WITH MORE OR LESS CONSTANT REGULARITY AND THUS BE ABLE TO GIVE AN ADJUSTMENT AT THAT TIME AND VERY MATERIALLY STEP-UP OUR EFFICIENCY IN HEALTH SERVICE.

Therefore the question: WHEN is a subluxation?

ADJUSTMENT, PER SE, IS NOT MODIFIED BY ABOVE

This subject discussed should technically confine itself to two salient issues, viz., periodicity of dis-ease as caused by periodicity of subluxation as its cause; and whether demand and supply creates, is created, or modifies evidence secured in understanding same. One subject, involved with so many angles, cannot be discussed by itself without being involved with other closely allied. It is natural that another phase attach itself, viz., in what way, if any, does "the adjustment with that extra something, having staying-put value" affirm or deny itself in connection

therewith. Above confines itself TO VERTEBRAL SUBLUXATION AS A CAUSATIVE FACTOR; ITS FREQUENCY IN BEING PRESENT OR ABSENT, AND WHY.

It is peculiar to suggest that subluxation can be present and yet be absent, and still be a subluxation. However, that expressly states exactly what I mean. A vertebral subluxation, to be technically and correctly understood, is any vertebra that is not in PERFECT apposition to its co-respondents above and below, with all abstract elements understood to be adjoined (with which we are not now concerned), such as occlusion of foramen, pressure upon nerves, interference to transmission, etc.

A vertebral subluxation is generally and usually loosely construed to be a vertebra that has gotten out of normal place and is permanently anchored in some abnormal position, from which position it does not vary until adjusted, either by accident or intention. In lay terms, this description may be sufficient. A vertebral subluxation is a vertebra which has, in part, on one or more places, lost its true, perfect, and exact corresponding relation with its each and every particular facet, superior or inferior; from which position it is rarely found anchored. All of us have seen balancing rocks, where a large body above rests upon a large base. At no time is the balancing rock unbalanced to toppling over, but it is always unbalanced in varying degrees. It might and does rock in any and all directions; sometimes more out of perpendicular and plumb—other times less. If it ever becomes completely unbalanced, it will be dislocated. The same condition exists with a vertebra that is subluxated. Not being seated in normal, with a true, firm, solid foundation between its superior surface to inferior surface vertebra above; or being true and firm with a solid foundation between its inferior surface to superior surface of vertebra below, it tends to be unsettled and sways from one position to another; sometimes swaying more, sometimes less. From the moment a subluxation occurs, it begins a growing movement of hoboing, roving, and roaming about; moving from one minute place or position, from one degree of abnormal position to another; at some times creating greater occlusion, pressure, and interference than others; ALWAYS doing SOME damage; sometimes more, sometimes less; ALWAYS destroying SOME degree of abnormal energy flow; some-

times observable with an NCM and sometimes so minute in its interference to produce the resultant resistant heat, we can ascertain its presence; when the opposite occurs and it tends to seek its more nearly normal position and minimize the abnormal position, and thus be little interference to reduce resultant heat, we cannot always ascertain its presence because its range is less than even that sensitive instrument; BUT NEVERTHELESS A SUBLUXATION IS ALWAYS PRESENT IN EITHER EVENT. IT IS THOSE CONDITIONS, BOTH LARGE AND SMALL, THAT WE HAVE BEEN DISCUSSING WHEN WE TALKED ABOUT PERIODICITY OF DIS-EASE IN CONNECTION WITH PERIODICITY OF SUBLUXATION AS WELL AS WITH THEIR RELATIONS WITH LAW OF DEMAND AND SUPPLY.

Existing long enough, some day, those subluxations will multiply and amplify their symptoms, pathologies, and dis-eases until they become so grossly apparent that patient understands he is sick in an end-organ. A demand for RELIEF will obtain. He may consider a Chiropractor, little thinking that it now does lie within the realm of aid of a competent, efficient, and honest Chiropractor to actually establish a permanent health in that body by reversing its cause, with hope that he CAN and WILL locate THE vertebral subluxation that IS his cause, correct it, and health will be fully restored to his body.

In the past, the average Chiropractor's concept of what constituted an adjustment was generally and loosely construed to be gradual replacement, step by step, degree by degree, of a vertebra out of normal situ, to rack it from its abnormal anchored position, and gradually replace it to its normal position until it finally becomes anchored again. Eventually, if he kept hammering away long enough, he MIGHT get it back to some sort of normal position where it MIGHT stay. Little did he think that it could be done ONCE and REMAIN. It might be like a surgeon who, having a dislocation, was to take months to gradually replace it to normal position, degree by degree, day by day. On the contrary, we do know that he does it ONCE and it remains.

When Chiropractic was born and was young, medical men ridiculed "chiropractic" because it hypothecated the theory that all vertebrae of spinal column could be subluxated. Medical men knew this was not true. Medical men pointed out that all verte-

brae were automatically "locked" by and thru their varied articulations between themselves. Peculiar, now, in, 1934 we agree for same reason. It is wonderful, tho, that we did not know this all these years. If we had, Chiropractic would have died aborning. We would never have known that SOME vertebrae COULD BE subluxated, nor would we eventually have found THE SPECIFIC FOR THE CAUSE OF ALL DIS-EASE. Our continuous ignorant stabbing away at ALL vertebrae (that could not be subluxated) plus jabbing away on two THAT COULD BE, occasionally and accidentally got a percentage well. Between many false "subluxation" failures and occasional true SUBLUXATION successes, it kept Chiropractic alive until now the day HAS arrived when we DID discover WHERE SUBLUXATIONS COULD BE IN FACT.

Today the scientific Chiropractor has a concept that there IS ONE DEFINITE, EXACT, AND CERTAIN SEATING PLACE FOR EVERY ARTICULAR FACET OF THAT VERTEBRA SUBLUXATED AND THAT THERE IS ONE DEFINITE, EXACT, AND CERTAIN SEATING PLACE WHERE THAT VER-

Illustration No. 10.

Osteological specimen. Acute angular kyphosis in middle dorsal region. Entire section necrosed, exostosed, and ankylosed. Sectioned from before-backward; two lateral halves opened up showing internal sections. Spinal column very much shortened. Specimen from The Palmer School of Chiropractic Osteological Studios. Illustration 11 is an enlargement of the angular section.

Illustration No. 11.

Osteological specimen. Enlargement of center section of Illustration No. 10. Sectioned from before-backward; two lateral halves opened up, showing internal section, more particularly the intervertebral foramina. Note Swanberg's statement regarding ankylosed vertebrae and decreased foramina and their inability to produce pressure upon nerves passing thru therein.

Specimen from The Palmer School of Chiropractic Osteological Studios. Illustration No. 11 is an enlarged section from center of Illustration 10. Illustration No. 17 is the cervical sectioned portion of this spinal column.

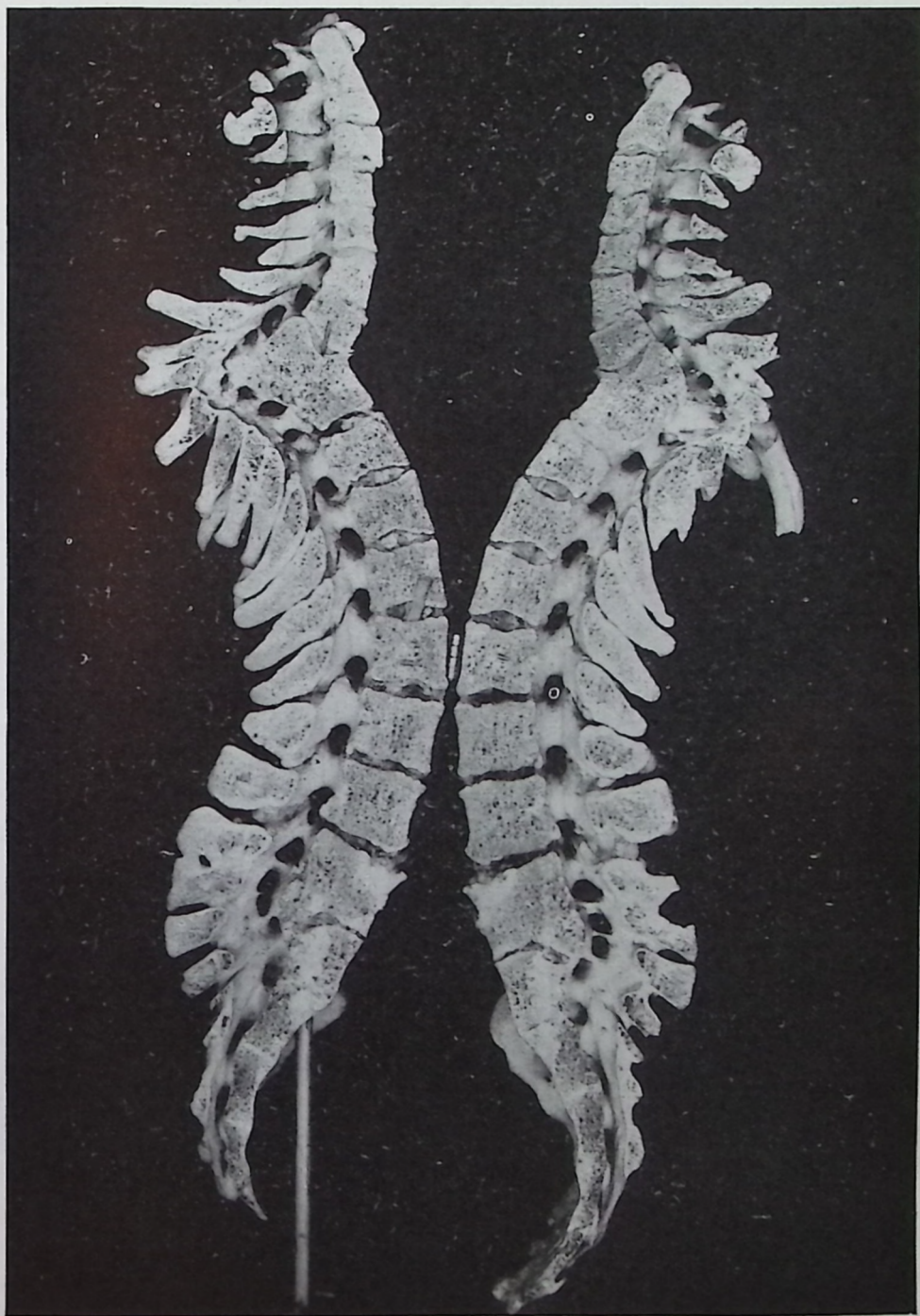


Illustration No. 10

TEBRA MUST EVENTUALLY BE RESTORED; AND WHEN IT IS, WILL PERMANENTLY CEASE ITS HOBOING, ROVING, AND ROAMING ABOUT; THAT WHEN IT ONCE IS ADJUSTED TO PERFECT SETTING IN RELATIONSHIP TO ITS CO-RESPONDENT VERTEBRAE ABOVE AND BELOW, IT WILL AGAIN BE ANCHORED TO WHERE IT BELONGS FOLLOWING WHICH THERE WILL BE RESTORED A PERFECT FUNCTIONAL FLOW OF FUNCTIONAL ENERGY TO THE SICK BODY.

In the past, the average Chiropractor was taught that HE was able to bring this about, so he proceeded to punch, shove, twist, wrack, and wrench the 24 vertebral bones from occiput to coccyx, continuing for an indefinite period from one week to years; on as many as six places on up to where now some are taking in 24 vertebrae three times up one side, three down the other; to where others are hitting away as often as every five minutes on as few or as many; hoping, praying, thinking, and believing that health might, perhaps be reestablished by him. In recent years, our clinical laboratorical research has convinced us that such has

Illustration No. 12.

Osteological specimen. Spinal column. Rare distortion including all kinds of curvatures. Posterior view. Specimen from The Palmer School of Chiropractic Osteological Studios. Illustration No. 13 is an enlarged section from this view.

Illustration No. 13.

Osteological specimen, enlarged. Center section of Illustration No. 12, anterior view. Note Swanberg's statement regarding ankylosed vertebrae and decreased foramina and their inability to produce pressure upon nerves passing thru therein.

Specimen from The Palmer School of Chiropractic Osteological Studios. Illustration No. 13 is an enlarged section from center of Illustration No. 12.

Illustration No. 14.

Two spinal columns, anterior views. Note entire sections heavily exostosed and ankylosed. Specimens from The Palmer School of Chiropractic Osteological Studios. Illustration 15 is an enlarged section of cervical regions of these two specimens.



Illustration No. 11

been found many times to be impossible, by intent, and only occurs occasionally by accident. Occasionally such DID ACCIDENTALLY happen, and health was restored; at least in a sufficient number to prove the principle and practice sound, when the accidents happened. Too many times it did not happen and in many instances the opposite occurred. Cases were made worse by the meddling of man in wrong places, in wrong directions, at wrong times. The reason for our failures lies in the fact that WE thot OURSELVES competent to know more than we did about many conditioning elements that were at all times BEYOND THE REALM OF MERE MAN. We thot our fingers "could feel a subluxation" and our mental studies could "determine where a pressure upon nerves existed." Today we rely upon the Spinograph and NCM to go beyond man into the realm of science to prove it for us. We are now compelled to go beyond the physical action of mere educated man to accomplish the ultimate desire of a perfect complete and exact setting of the vertebra in that act called AN ADJUSTMENT OF A VERTEBRAL SUBLUXATION.

(See further discussion under "Adjusting," Chapter XII.)

Illustration No. 15.

Cervical sections of spinal column in Illustration 14. Note Swanberg's statement regarding ankylosed vertebrae with decreased foramina and their inability to produce pressure upon nerves passing thru therein.

Specimens from The Palmer School of Chiropractic Osteological Studios. Illustration 15 are enlarged cervical sections of two specimens in Illustration 14.

Illustration No. 16.

Lower dorsal and lumbar regions of spinal column with marked acute angular kyphosis. Right lateral view showing ankylosed vertebrae with marked decreased size of intervertebral foramina. Note Swanberg's statement regarding ankylosed vertebrae with decreased foramina and their inability to produce pressure upon nerves passing thru therein.

Specimen from The Palmer School of Chiropractic Osteological Studios.

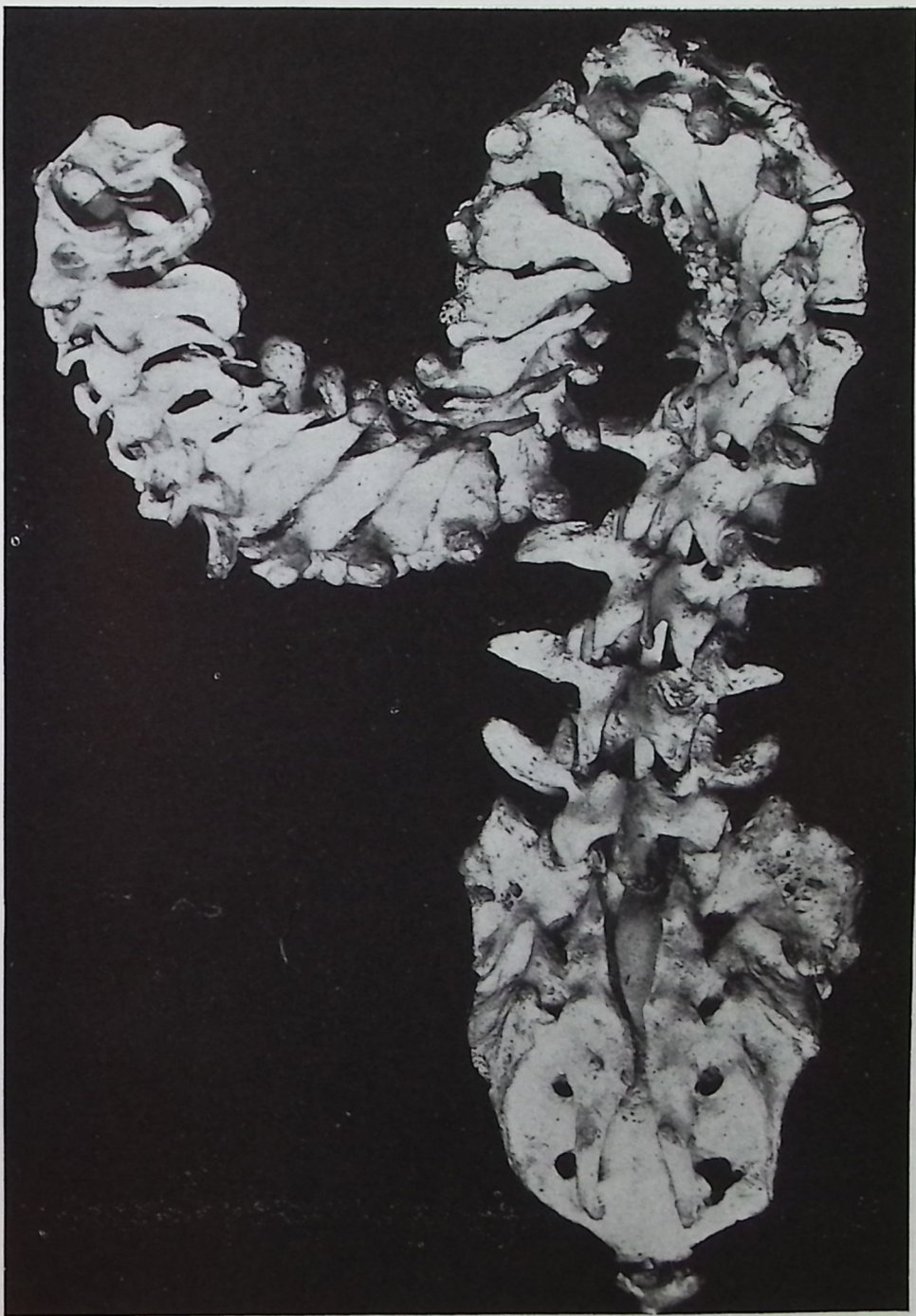


Illustration No. 12

Today we clearly understand that there is only ONE intellectuality—THE INNATE INTELLIGENCE WITHIN THE BODY OF THE PATIENT—that DOES know what normal and perfect position of a vertebra is; what it was before it was subluxated when it was normal; understands clearly how far and how much it is out of that perfect setting and knows exactly how, where, and when to replace it back to that normal perfect apposition with its each and every articular facet, with its co-respondents above and below, with which it has grown together from babyhood to the present hour.

Today the Chiropractor approaches his case as a problem, desiring to work WITH THIS INNATE INTELLIGENCE IN BODY OF PATIENT THAT INNATE IN PATIENT MIGHT MAKE THE ADJUSTMENT; thereby, ONCE AND FOR ALL, correcting the vertebra to its ABSOLUTE NORMAL position. In exact ratio as this understanding of the principle applies itself correctly, we reduce the number of times WE ATTEMPT to make an "adjustment" by ultimately letting Innate Intelligence do IT ONCE. WHEN THIS INNATE ADJUSTMENT HAS TAKEN PLACE, it no longer hobbles, roves, or roams about. It is established where it belongs. It is anchored in its normal setting to which, for which, and by which it grew. ONCE THAT ADJUSTMENT OCCURS, all that we may have suggested about the off-and-on periodicity of SUBLUXATIONS ceases to exist. On the very reverse, we have AN ANCHORED VERTEBRA,

Illustration No. 17.

The cervical region of specimen in Illustrations 10 and 11. Sectioned from above backward. That the case had a pathology is obvious from the study of those views. Note approximation of posterior arch of atlas with spinous process of axis and 3rd cervical. Atlas would be listed as anterior and superior. Anterior arch superior and riding on axis odontoid process. Axis would be listed as posterior and inferior. Note position of odontoid process into neural canal. Pressure would be between superior of odontoid process on spinal cord not only in neural canal but between superior of odontoid process and magnum foramen.



Illustration No. 13

ANCHORED BY THAT ADJUSTMENT WITH THAT EXTRA SOMETHING, WHICH HAS STAYING PUT VALUE.

There is a distinction, in this discussion, between what we may say about the off-and-on roaming about of a subluxated vertebra, and that ANCHORED VERTEBRA ONCE CORRECTLY ADJUSTED.

SCIENCE DUPLICATES ITSELF

Astronomy can tell by stars, in past, when there WAS an eclipse of sun or moon. Astronomy can tell by stars, in future, when there WILL be an eclipse of sun or moon. Astronomy IS science because it can duplicate itself with accuracy, efficiency, and correctness. Different men, in different parts of the world, using same process of exclusion, will reach same definite conclusions.

Mathematics can multiply, divide, add, or subtract objects, things, ideas, or what have you. Any man can do the same, any place, at any time—past, present, or future.

Chemistry is as scientific for same reasons.

- (a) Given 16 elements in a given known quantity
of a given known quality
mixed in same sequence
at same temperature
you'll always get same chemical net result.
- (b) Given 2 LESS elements in a given known quantity
of a given known quality
mixed in same sequence
at same temperature
you'll get a DIFFERENT chemical net result.
- (c) Given 16 elements in VARIED quantity, by subtraction
or addition
of a given known quality
mixed in same sequence
at same temperature
you'll get ANOTHER DIFFERENT chemical net
result.
- (d) Given 16 elements in a given known quantity
of a given known quality



Illustration No. 14

mixed in DIFFERENT sequence
at same temperature
you'll get still another DIFFERENT chemical net
result.

- (e) Given 16 elements in a given known quantity
of a given known quality
mixed in same sequence
at DIFFERING temperatures
you'll get still another DIFFERENT chemical net
result.

Chemistry is a science because it is governed by chemical law.

Every Chiropractor knows that if you want RESULTS OF LAW, you must work WITH LAW. Yet the average Chiropractor thinks he can add or subtract, divide or multiply quantities, qualities, sequences, temperatures to suit prejudices, prides of opinions, greeds, in Chiropractic, and attain a normal LAW result. He VIOLATES CHIROPRACTIC LAW and hopes to get RESULTS OF CHIROPRACTIC.

Science is the ability to establish facts subject to being proved and demonstrated by the use of exclusive processes of reasoning; eliminating failure elements; accumulating successful elements; and the ability to repeat those facts proved and demonstrated by same use of same exclusive processes of reasoning; eliminating failure elements, the same as before; accumulating successful elements as before.

Until the discovery of the specific of the cause of dis-ease as now confined to the inter-magnum-atlas-foramen and odontoid process and the part it plays between atlas and axis, the Chiropractic profession had gotten sick people well. But no matter upon whom it accidentally and occasionally happened, it was difficult, if at all possible to repeat or duplicate the occurrence. A case of asthma would get an adjustment some place, some way, and the case got well. Nothing was definitely known, nor could any one positively assert where or how the event took place. That it occasionally occurred was certain. The patient was pleased. Some day the asthma might recur. When it did, we would attempt to duplicate the event and in a vast number of cases, failed as readily as we succeeded before. Why? That



Illustration No. 15

was the problem NOT answerable within the state of our knowledge or art then.

At Tulsa, we met a case in point proving the new work and its being not only within the realm of our present knowledge but subject to being repeated, duplicated, no matter how many times. Whenever this case would turn his head to the right, he could urinate without difficulty. Whenever he turned his head to left, it would stop as suddenly as though he suddenly turned off a faucet. He had been doing this for years. Never does it fail. Clearly, when he turned to right it released pressure and restored transmission to the necessary organs and produced the necessary normal organic function. When he turned to left, it produced pressure and interrupted transmission to the necessary organs and interfered with the necessary normal organic function. No matter how often he performed the "trick," the "trick" always worked thus proving the elements of proving and demonstrating a scientific fact.

The case of Stella Workman is also in point. While conducting a week's review in Los Angeles, Stella was in an automobile wreck and was made instantly blind in both eyes. Spinographs were taken within an hour and read according to the torqued subluxation. NCM readings were made and an interference found at a certain place. The adjustment was given by the writer in accordance with the rules herein laid down to untorque the torqued subluxation. One adjustment was given on day of accident; another check and adjustment made next morning; and within less than 24 hours, sight was completely restored in both eyes.

Approximately one year later, the same case fell head-long down a stairs at a trial held at San Jose, Calif., where the writer was again present. She was picked up again totally blind in both eyes. The writer reasoned that the same subluxation would be present; subluxated in same way; at same place; and same kind of an interference would be present. Like effects, like cause. Like cause would produce like effects. The case was read with NCM for interference. Interference was found at same place as before. If subluxation was the same, it would require the same kind of an adjustment to secure same results. The adjustment was given at same location; same direction;



Illustration No. 16

with same objective as done one year before. Within 24 hours, again sight was completely restored in both eyes. Science is that ability to correctly repeat itself again as in the first instance.

Another case in point. A laborer in a wholesale grocery store was up-ending a barrel of salt. He wrenched his back and "lumbago" was the result. He went to a Chiropractor who punched his back from top to bottom, emphasizing 3rd lumbar. The case told this story: "I heard something pop in the small of my back. Immediately after, a bump appeared which I could feel, in the small of my back. It was sore to touch and surrounding tissues were tender." This Chiropractor kept case for one week, with no results. He then referred the case to the writer. The writer, pursuant to his present scientific work, confined his search for THE CAUSE to such place where there WAS an interference to transmission, rather than to rely upon anything the case might say about his condition that might influence the judgment as to what and where.

An NCM interference was found at axis. NO interference was found at or in vicinity of lumbar region. The case was bent over and with difficulty was able to get down on adjusting table. An adjustment was given ONLY at axis, in a certain direction. The case got up off table straight as a die; the bump in small of back was gone; tenderness was entirely absent, and the man was as good as new. He returned jubilant to the first Chiropractor to report. This first Chiropractor was chagrined to note that we had done nothing to the lumbar region "where the subluxation must have been." Notwithstanding the case was WELL, the local Chiropractor insisted upon "adjusting the lumbar 'subluxation'." Immediately the man got his "crick in the back," he got up with lumbago and was hunched over and could not get up straight.

(For reasons why this remote control "adjustment" REPRODUCED the major, torqued subluxation, at axis, we refer you back to full explanation in Chapter V.)

Next day, case returned to the writer as bad as he was day before. If science is right, we should expect to find the interference in axis region and not in lumbar region; subluxation would be at axis and not in lumbar; and the same adjustment

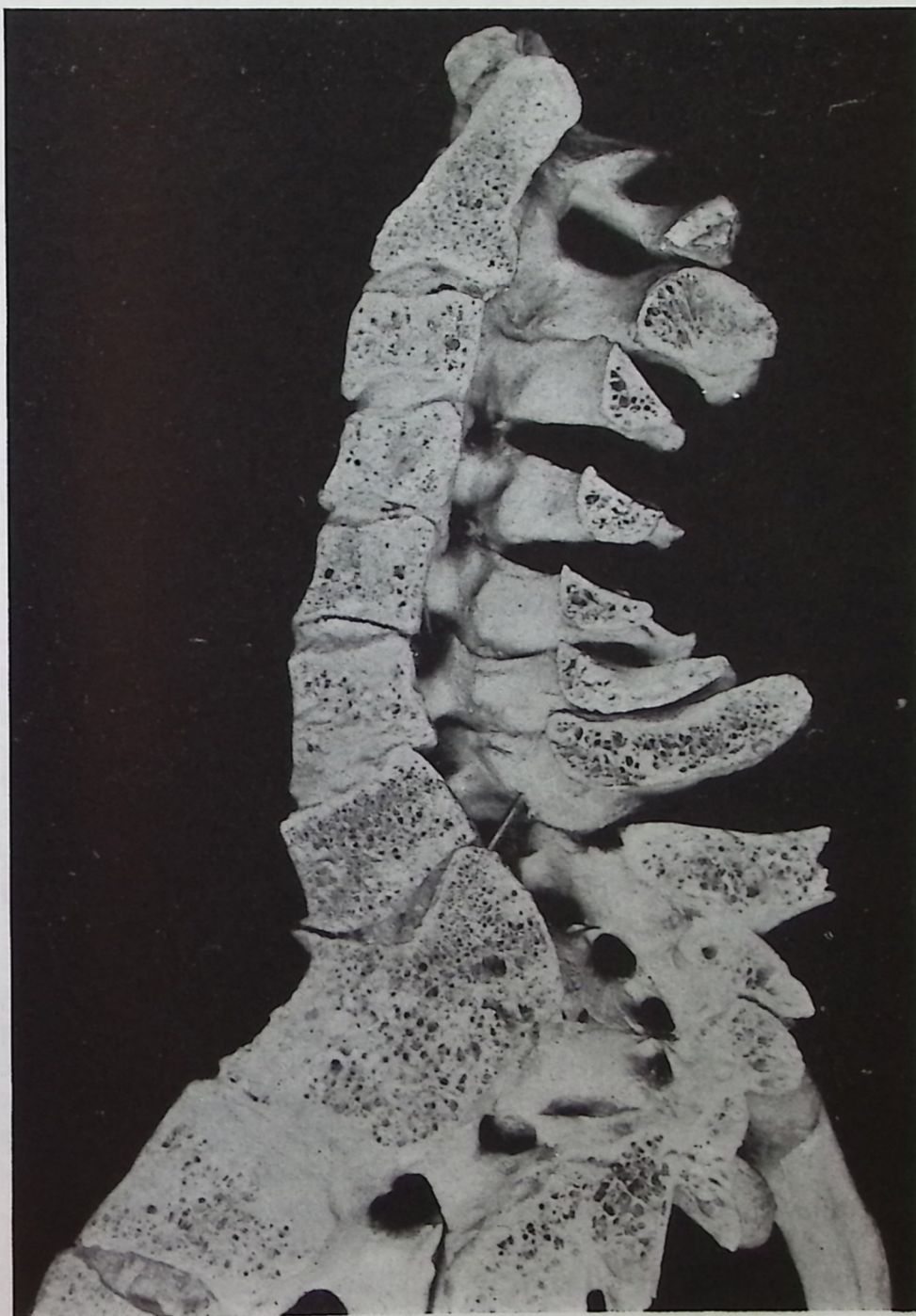


Illustration No. 17

given at axis, second day, as was given first day, should get same results. An NCM reading was made. An interference was found at axis and none was found in lumbar region. The bump was again in lumbar region; the tenderness was present, etc. Adjustment was given at axis in same direction as on previous day. The case again got up straight with bump and tenderness gone. Science is that ability to as correctly repeat itself as happened in the first instance.

Now that we definitely know the nature of the torqued major subluxation; can ascertain which vertebra IS the torqued subluxation; and can ascertain where and when interference is and is not present, we can be certain of duplication of our cases, thus proving that Chiropractic IS A SCIENCE.

Gradually, by process of exclusion and elimination of failure; gradually the process of exclusion and the accumulation of success has delivered into our hands a knowledge of THE human principle and practice, its location and correction, of THE cause and THE adjustment of that cause of ALL dis-ease, regardless of what the sick thinks, says, does, or believes. THAT is the knowledge and practice we NOW present to the exclusion of all other knowledges and methods we have ever presented. It is THIS knowledge and practice, when exclusively used, that now knowingly and intentionally materially steps UP percentage of success and steps DOWN percentage of failure out of all proportion of all previous experiences in the history of securing health to the sick, in the history of mankind, regardless of century, name, or method.

It is regrettable that space in this book on scientific Chiropractic advancement must affirm or deny obvious personal issues. So long as members of our profession are influenced to stand still by prejudicial complexed inductions, then we are forced to explain hypotheses that ought to reason themselves.

Some affirm that the Author is "inconsistent" because he affirms principles or practices one year and denies some of them the next; that he settles on some and denies others, always enlarging or diminishing concepts, etc. The only thing PERMANENT is change! Progress is evolution. Out of every 1,000 experiments, ideas, inventions, devices, thots, principles, or practices developed, one is good and works to the PERMANENT

uplift of human race. Growth is a flight of stairs. The step we were on yesterday was good YESTERDAY. The step we are on TODAY is good today. The step we are on TODAY, which we affirm TODAY denies the step OF YESTERDAY, tho good YESTERDAY. We needed the step of yesterday to climb to the step today. Without yesterday's step, there could be no today's step. Yesterday's step supports today's step. Without yesterday's step, today's step could not exist. The more we climb, the more steps we see ahead. There is NO TOP to the flight. The vista enlarges the higher we go and grow. Why step BACKWARDS on step of yesterday because it is there; was there yesterday; stood on it yesterday; found it good yesterday, and it upholds the step of today? Standing on today's step, I look forward to using TOMORROW'S step. I LCOK FORWARD AND UPWARD, not DOWNWARD OR BACKWARD. To say one is "inconsistent" because he refuses to stand on THE SAME step all his years, is to admit that any man who grows, expands, moves upward IS inconsistent. It would be equivalent to saying, in reverse language, that any man who expands concepts, enlarges horizon, grows and renders better service is "inconsistent." He who presents this theory of "inconsistency" is using our methods of 20 years ago when he graduated from The PSC. He admits having bought seven automobiles since, each a later and better model. He grows as cars grow, but refuses to grow with that profession that BUYS the cars. By his own token, HE is "inconsistent."

Criticism has been directed against B. J. Palmer, HIO system, and the PSC for advocating, using, and teaching the exclusive process of adjusting only one place, in one way, when the facts of deduction conclude this is the efficient, competent, accurate, and honest thing to do. It is said that: "If you go to The PSC you will be taught to adjust only ONE place; ONE way; whereas we teach you to adjust MANY places, MANY ways; we give you more for your time and money."

If it is hit-or-miss guess-work desired, then theirs is the place to go. If it is results attained by science demanded, then The PSC teaches it. If a person with less rhyme or reason desires much, regardless of its net result to the sick, then theirs is the place, and The PSC is not the place—for that is what they teach

and what we DO NOT teach. If education is wanted which will competently fit a person to know principles and practices of medicine under a Doctor of Chiropractic (D.C.) degree; which will train him to study superior brands of medical anatomy, physiology, pathology and diagnosis with centuries-old mistaken failures; if intricate duplication of book effects of disease is desired; if student wants to master diagnostic instruments to meet Chiropractic failure with medical men of an equal degree of ethical incorrectness, then "chiropractic" institutions exist for the express purpose of catering to such types of prospective students. If education is wanted which will competently fit a person to know NEW principles and practices of this NEW Chiropractic philosophy, science and art; which will train him to analyze, locate, prove presence and absence of CAUSES of dis-ease with a modern NEW ability to get sick people WELL and STAY WELL; if they are not afraid to step into an original NEW field of research; if a prospective student is willing to educate the public to a NEW successful method, then there is ONE school which is doing that to a marked degree. What a patient has to tell a Chiropractor about how he feels, means absolutely nothing to a competent chiropractor. It is what a competent chiropractor has to tell a sick patient that means absolutely everything. A successful chiropractor is not a successful diagnostician, and we cannot visualize a successful diagnostician being a successful chiropractor. What does it gain "a chiropractor" if he diagnose dis-ease correctly according to orthodox medicine, and he cannot give an adjustment of a vertebral subluxation letting Innate get the sick well? What does it gain a sick man if he gets an adjustment and gets well according to orthodox Chiropractic, and he does not get a diagnosis according to orthodox medicine? The PSC regards scientific efficiency, competency, accuracy, and honesty, attained by the exclusive process of deduction of facts, as more valuable than merely acceding to the past desires of patients who want much time, much fiddling and fooling upon themselves as a desideratum.

To criticize The PSC because of its exclusive process and method, is to commend our institution as a scientific institution, for that is the method of science, of scientists — to arrive at

definite scientific conclusions by the exclusive scientific method of knowing what they scientifically do; where they do it; when it is scientifically necessary to be done. The facts of astronomy, mathematics, and chemistry or any other science, were reached as scientific facts only by the singleness of exclusive conclusions based upon deductions reached by that method. No person who does much, many ways, at the same time, upon the same case, ever KNOWS what he is doing.

All criticism directed against B. J. Palmer, HIO system, and The PSC for advocating, using, and teaching the exclusive process of adjusting only one place one way, for one reason, based upon scientific facts reached by deduction in establishing an efficient, competent, accurate, and honest method, is at once a compliment to the scientific nature of our work.

(See Foreword and Seeking Specifics, Chapter I.)

Illustration No. 18.

For many years, the Chiropractic profession has epitomized their principle with that characterisic set of vertebrae showing a lateral view of a vertebral "subluxation" with the occlusion of intervertebral foramina. This view will supplant that as more truly typical of the "Hole in One" construction of Chiropractic.

Illustration No. 19.

A companion comparison picture to Illustration No. 18. Current is generated in the dynamo (brain); it is transported down thru wires (nerves) to the globes (organs and viscera). The switch (the vertebra) can be moved thereby offering resistance to transmission; reducing the quantity flow and reducing the quantity of current (mental impulse supply) to the globes thus reducing the quality of light (life). To "adjust" the switch is to RESTORE the transmission of normal quantity, thus RE-ESTABLISHING the normal quantity of light.

Illustration No. 20.

This illustration (enlarged of Illustration 19) is destined to replace the one so long used by Chiropractors as described in Illustration 18. It locates the atlas and axis with their pressures upon the spinal cord, at base of the brain, as THE SPECIFIC OF THE CAUSE of all dis-ease. The "kink" interference-pressure is shown clearly. Altho this is but one of the many ways by means of which the odontoid can produce interference, yet it depicts the story of Chiropractic.

Illustration No. 21.

A companion comparison picture to illustration 18. Water can come from the hydrant but if there IS a kink along the path of the hose, water cannot get thru the kink to get to the nozzle. Treating effects at the nozzle, for hours, weeks, or months, will never restore water in its transmission to come down to the nozzle and come thru that nozzle to sprinkle the grass, flowers, or crops. Crops cannot grow without water; water does not come out the nozzle; water cannot come thru the nozzle because it isn't coming TO the nozzle. It isn't coming TO the nozzle because it can't come THRU the kink, no matter how much may be back in the hydrant. Unkink the hose and the water will flow normally and accomplish normal function at the nozzle.

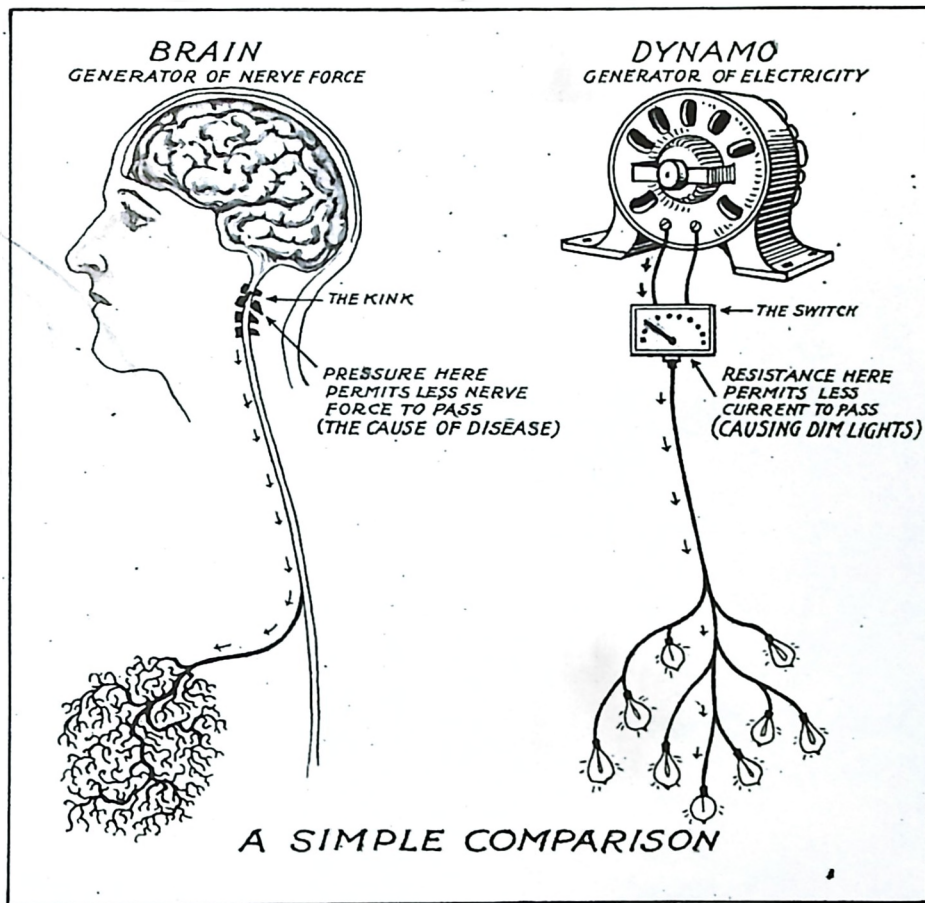


Illustration No. 18

Illustration No. 19

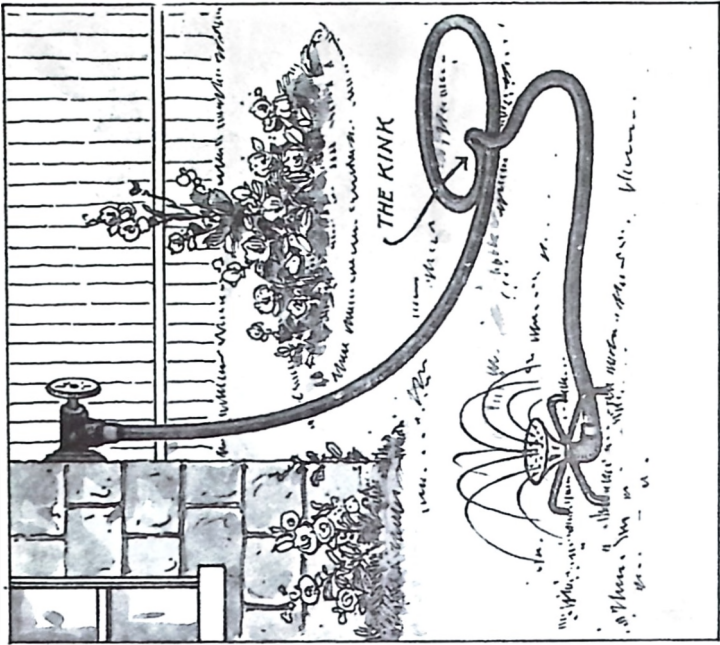


Illustration No. 21

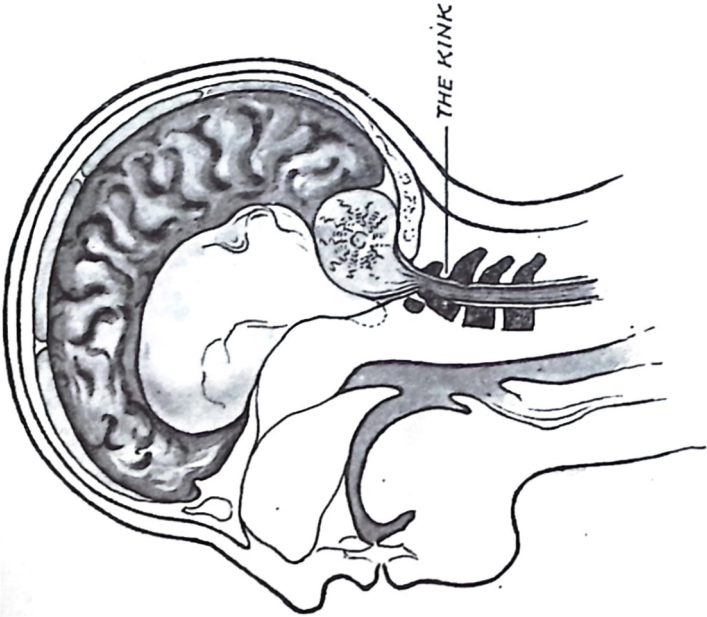


Illustration No. 20

CHAPTER VI.

CHIROPRACTIC NEUROLOGY

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THE writing of this chapter on Neurology necessitates briefness because Neurology is an inexhaustible subject. Therefore, only portions of the subject will be referred to in order to clarify the following points: (1) The limitations of anatomical neurology; (2) the broader and more elaborate field of clinical findings; (3) the importance of the nervous system as to the source of life; (4) that there is a cortical center for every function; (5) that there is a direct continuity between brain cell and tissue cell; (6) the location of fibers which are subject to pressure which either directly or indirectly supply the entire body; (7) that the Neurocalometer is a scientific instrument; (8) the building of an adjustor; (9) the building of a Chiropractic brain; (10) what constitutes efferent and afferent cycle of function; (11) the focusing of all branches of the Chiropractic profession.

The study of Neurology in the past has been confined largely to anatomical findings. There has been more study and research on Neurology than all other branches of anatomy. A few years ago the knowledge of it was limited compared with what we now know. The vast amount of present knowledge, is limited in comparison to what yet remains to be found. The knowledge of tomorrow will be greatly increased because every day we awaken to new findings.

The Chiropractic principle has been questioned because we refused to be bound by the limitations of tradition and have deviated from the field of anatomical findings into more elaborate field of clinical findings. Only a very small portion of the nervous system has been discovered by the anatomical method. This is proved by the fact that more and more is being discovered each year. It is proved further that there is a very large portion of the nervous system that never would have been discovered if we were confined to the limitations of anatomical findings.

There are many things in science which are of a clinical na-

ture. Progress in Chemistry has been made by experimentation. Experiment after experiment has builded the chemist's knowledge of reactions of various elements under given conditions. Today, it is known as a science. Even though a science, chemistry has not reached its limitations. Tomorrow will bring new ideas in this particular field.

Electricity has been developed through various experiments (clinical findings). Franklin flew a kite into a black cloud, and there was something conveyed from that cloud through a connection which he had with the kite. He did not know what it was, and for many years others have been trying to solve the question. They call it electricity, but what is it? Edison took Franklin's findings and produced an incandescent lamp. Day by day we acquire increased knowledge of electricity, but the question unanswered is, what is electricity? New ideas are born in men regarding it. They make discoveries from experiments, and these are given to the world. The public is educated into a receptive mood. It is easy to say that we do not believe such things are possible since we have not had experience or proof of their working principle. But as we become educated to the application of this principle, we are willing to accept conveniences obtained from it. No one takes the attitude that he is not going to have electrical appliances until someone discovers what electricity is.

The development of radio has been clinical. We do something with a broadcasting apparatus, and test what we do by what is received through another apparatus some distance away. What is it that connects these two apparatus? It has been called ether. They philosophied that it is in the air, but no one knows its nature. Most of us are content to be seated by our fireplace and be entertained, many times with programs from foreign countries, but we never realize that the thing connecting our receiving set with the broadcasting station thousands of miles away, is something which has been developed solely from clinical findings.

It might be said that an automobile is builded from scientific knowledge. Scientists know the tensile strength of steel, the ratio of gears, the gravity line of balance, the construction of framework, etc., but nearly all factories have a test department

where the automobile is put under an acid test of service. Many things which scientists were thoroughly convinced were working principles have fallen by the wayside because of this clinical test.

Wright Brothers observed birds of the air. Born in the minds of these boys was an idea that some apparatus could be built which would afford transportation for man through medium of air. They built a crude structure. Scientists called them crazy because the law of physics had proved that all structures heavier than air would seek gravity level. They refused to be bound by limitations of science and made a test. Disappointing as it was, there was something about it which inspired them to go on with their idea. A few years ago a monument was erected, at the place where they made their test—at Kittyhawk, North Carolina. We are living in a new age because they refused to listen to limited knowledge of scientists. The world today accepts the aerolplane as a modern convenience.

So in the study of Neurology, it is not logical to limit our study to anatomical findings. There are many things which have been discovered in the study of nervous system from clinical findings which may never be discovered anatomically.

Briefly, the embryonic development of brain and nervous system, anatomically, starts from the blastoderm which consists of three layers known as: The epiblast, the mesoblast, and the hypoblast. We are particularly interested in the portion of the blastoderm from which the nervous system is developed — the epiblast. It is the outwardmost layer of the blastoderm. Cells from this layer must be brought into final location of the nervous system, the larger portion of nervous system being deeply located within the body. The first thing noticed in development of the blastoderm is the process of invagination. This is called the primitive streak and consists of a thickening of epiblast. It gradually develops into a neural canal, the edges of which fuse to form the neural tube. This tube is divided by constrictions into three primary vesicles, namely: The proscencephalon, the mesencephalon, and the rhombencephalon. The first and third primary vesicles divide forming, in all, five secondary vesicles, namely: The telencephalon, the diencephalon, the mesencephalon, the metencephalon, and the myelencephalon. From the secondary vesicles is developed the nervous system. Since the primitive

streak is the first development of blastoderm, importance of nervous system seems to be magnified.

Neurologists have divided the nervous system into the cerebrospinal or central nervous system and what has been called the sympathetic system. The cerebrospinal system consists of the brain, spinal cord, and forty-three pairs of cerebrospinal nerves. What has been called the sympathetic system is Chiropractically termed the PERIPHERAL VISCERAL SYSTEM, and consists of a gangliated cord from base of brain to tip of coccyx, pre-ganglionic fibers from spinal cord, and postganglionic fibers from ganglionic trunk which form complicated plexuses. They have been taught as two different and distinct systems. I do not agree with this. They are parts of one nervous system, and there is no line of demarcation.

The human brain weighs forty-eight to fifty ounces. The male brain is larger than the female brain which, no doubt, is due to the increase in development of motor centers. The cerebrum, anatomically, is divided into right and left hemispheres. Each hemisphere consists of seven lobes, namely: Frontal, parietal, occipital, temporal, central, limbic, and olfactory. These are separated by fissures which divide the cerebrum into different portions for convenience of study.

The cerebrum consists of the cortex and the medullary portion. The cortex has four layers, from outward-inward: The molecular, small pyramidal, large pyramidal, and polymorphous. The medullary portion consists of white fibers which are classified into three groups, namely: Projecting, commissural, and association. Projecting fibers consist of crura cerebri which connects cortex with pons, medulla oblongata and cerebellum. The commissural fibers consist of corpus callosum (the great commissure of the cerebrum), lyra, or hippocampus commissure, the anterior and posterior commissures. The association fibers connect different parts of cortex in same hemisphere and are classified as long and short association fibers. The long association fibers connect the cortex of distant parts as follows: The superior longitudinal connects frontal and occipital lobes. The inferior longitudinal connects occipital and temporal lobes. The perpendicular connects inferior parietal gyrus, occipital and temporal lobes. The uncinate connects frontal and tem-

poral lobes, and cingulum connects the limbic occipital, frontal and temporal lobes. The short association fibers, extend across the bottom of the sulci and fissures and connect the contiguous gyri.

There seems to be a great deal of philosophical and physiological study as to function of the association fibers of cerebrum. For example: Hearing is interpreted in acoustic center and this interpretation is conveyed to the center of memory. Vision is interpreted in visual center, and smell is interpreted in rhinencephalon. These interpretations are conveyed to the center of memory. All of these and many others are connected together by long and short association fibers so there is an harmonious accord of senses with which motor centers are connected and may respond to them.

Only a small portion of the cerebral cortex has been definitely located as to function, and this has been accomplished in a large measure, from clinical observation. That is, if there is a pathological change in the cortex, a study is made of what is affected, thereby gaining a limited knowledge of location of cortical center for that function. If a disturbance is made in cortex, it will interfere with function of organ connected with that particular part of cortex as there is a direct continuity between brain cell and tissue cell.

The motor center for right side of body is in left hemisphere, the motor fibers crossing in anterior white commissure of medulla spinalis and medulla oblongata. The motor center is located in precentral gyrus of frontal lobe. The tactile center is located in postcentral gyrus of parietal lobe. The acoustic center is located at posterior three-fifths of superior temporal gyrus. The visual center is located in cuneus gyrus of occipital lobe. The gustatory center is located in uncus of temporal lobe. The olfactory center is located in the rhinencephalon. The frontal lobe is the center of higher attributes of mind, memory, and knowledge.

In cerebrum are located several nucleii: The corpus striatum which consists of caudate and lentiform nucleii; claustrum; optic thalamus; hippocampus major; hypothalamic nucleii and many others. There has been a great deal of research to definitely determine functions of these various nucleii. At one time

they were of the opinion that optic thalamus was the seat of vision, and that was why it was so named, but it has a vast connection to all structures of the brain. It has not been definitely decided as to what is the extent of its function. The exact functions of these various nuclei to date are questionable. The cerebellum also has a cortex and medullary portion, but very little to date is known about its function. Might it not be a governor that controls the rhythmic action of muscles?

Anatomy has contributed little to what we know about the physiology of brain. Clinically, the brain is the source of nerve energy. Clinically, there is a cortical center for every function. There is a direct continuity between brain cell and tissue cell, and a break in this continuity, or an interruption, will cause a limited amount of mental energy to get through, therefore, tissue cell cannot be one hundred per cent in function, because of decreased amount of mental impulse which is the source of life. Chiropractically, the brain is dual; is divided into Innate and Educated.

"We make a distinction between Educated and Innate brain because it is only the kind or quantity of thought that gives to it the attribute of quality. Innate is a name same as Educated, but there is a distinction between; Educated being inferior, Innate superior; Educated being smaller, Innate larger; Educated being raw, Innate refined, thus giving aspects of kind, quantity and quality.

"I take that viewpoint because anything Educated thinks has never been thought in kind, quantity nor quality that Innate would think upon the same did she receive from the same source. We think of generation or reproduction of life; Educationally and Innately we think upon sex organs; Educationally we could not, nor have not been able to produce a single generative organ, we have never so thought in quantity, kind nor quality sufficient to make a generative tissue cell, let alone an organ or a set thereof, not considering the functioning generative organs, but Innately the mind has thought kind, quantity and quality sufficient to not only make one generative tissue cell but millions, form, position, functionate and reproduce them—all of which Educationally we could not do. Here is an instance of where two intelligences, residing within one unity have both thought upon

same issue, yet one makes and remakes, the other cannot even conceive. That shows there is a distinction.

"Man is two men, he is Educated and Innate. There are dual personalities in each and all. We are here together. But we, as Educated people, are ninety-nine per cent Educated fools. We have been taught that whatever we know Educationally—that was all; whatever was Educationally taught and whatever we accepted as Education, that was the height of knowledge, that there was nothing greater or higher; that was the summum bonum of Intellectual aspirations. Consequently, it is conceded that he who goes to school, colleges or universities the most; gets most from books, has the largest vocabulary of words; can string the greatest number of thoughts into ideas—that man is the best Educated man, that man stands higher in the viewpoint of the mass of people.

"Innate has been observing through a long space of time. This intelligence is a part of the entirety of the accumulation of thoughts. How old it may be I do not know, so old that it has been turning over man's matter, to such an extent that it represents to our Educated minds almost perfection, so that he who gives the greatest play to his Innate Intelligence in acting through the Education is the best knowledge condensor of facts known and of many facts unknown Educationally.

"Man educationally knows little; Innately much. Education is a reflection of what you possess, Innately; because everything you know Educationally, is, was, and will be first conceded, first known by your Innate, then handed to you to be Educationally thought upon, from which you will deduce a fact which might be in line with the known Innate knowledge fact.

"You should counsel with your innerself; with the other half of self. I use the term "other half" because it is necessary to divide myself into two to be a totality.

"I, on the reverse of most persons, believe that the animal, which perhaps has no Education, is our superior on the common ground that what we steal Educationally from Innate is not to our credit, whereas the animal, which does not steal anything, is a better Innate knowledge acting animal than we.

"Man is dual. This is true functionally, for by Educated volition, I cause my arm to move by certain thoughts; I might walk,

run, jump, swim, etc. Then there is another line of functioning over which Educationally I have no control.

"For instance, a bone is fractured. I have no control over that fracture, Educationally. It is Innate that comes to the fracture, expands osseous cells, makes ossific material necessary, deposits it in the right place, right quantity, unites segments, heals and causes it again to assume normal condition. It is Innate which heats or cools, causes secretions and excretions, controls all the essential nine primary functions which Educationally I could not control one impulse of let alone making the impulse in the right quantity, quality and right kind or deposit it at the right place at the proper time. Thus, we are dual on first concept.

"Psychologically, functionally or physiologically speaking, we are divided; therefore — those statements being true — we are philosophically dual. Anatomically, you will not find this division. Anatomically, a muscle is a muscle regardless of whether it pulls up or down, whether on the anterior or posterior of the arm, forearm or upper portion; upper leg or in the thigh, in the abdomen or upon the scalp. Regardless of location, muscle is muscle, bone is bone, nerve is nerve; but functionally speaking there are two kinds of muscles, nerves, men. There is that Educated man who Educationally thinks in an Educated brain, has Educated nerves to transmit those thoughts, Educated muscles to execute them, Educated afferent nerves to carry impressions to the Educated brain, Educated mind to interpret those impressions, an Educated mind to reason upon them and an Educated process of adaptation.

"Then, there is the Innate mind working through Innate brain, which has Innate efferent nerves to transmit Innate efferent impulses to the Innate set of muscles which muscles give origin to the impressions, and those impressions travel back to the Innate brain, where Innate mind thinks upon, interprets, and brings into play this high qualitative adaptative Innate Intellect. Thus man is divided into two—an Innate man and an Educated man.

"Each of these divides into subdivisions. Here is a left and a right Educated mind the same as there is a left and right Educated brain; then there is a left and right Innate mind, the same as there is a left and right Innate brain. So can we speak of the

right and left Educated thoughts and the right and left Innate thoughts, because the thought is made in a place for a place and the place where it executed shows the place where it was made and for what place intended. Consequently, there is a division in thought, according to the side upon which they may go.

"Each of these divisions are again subdivided. There is a left anterior and a left posterior Educated man, there is a right anterior and a right posterior Educated man. So we may go on with our process of division until we reach the conclusion that every cell is either Educated or Innate and have every tissue cell in its classification. Man is, at least in the broadest principle, a dual, systematically and mechanically made being.

"There are two scalps, a left and a right; two eyes, noses, tongues, mouths, cheeks, temples, ears, hearts, lungs, kidneys, bowels, legs, arms. You will say at first glance, 'I see where he has two eyes, noses, ears, lungs, legs, kidneys, arms; but I cannot see how two scalps, tongues, or bowels.' This is divisible clearly pathologically. Many is the individual who has a paralysis of the muscles of the scalp and only paralyzed on one lateral half, the line being as completely made if drawn from the bridge of the nose back to the spinous process of the axis. Hemiplegia-smile on one side of the face, the other being paralyzed, showing that the face is divided. Individuals taste upon one-half of the tongue and not upon the other or can talk with one half and not with the other.

"Individuals are deaf in only one ear; blind in only one eye; have a headache in only one-half of the brain and not in the other.

"Man is divided into divisions outlined. When you study brain anatomically, you must not lose the value of divisions of that brain functionally, carry that constant connection that exists between a portion of that brain and the steps through which it may go in carrying out its functions.

"The 'Brain System' includes the brain or brains, the function or functions, the Education or Educations, the names, locations; the spinal cord and all its tributary nerves, the aspect of its functions, where they go; also this anatomical brain in action. When you view matter, view what it does; what makes it act; how,

where the actions go; how they are transferred from place to place. If you take that viewpoint, 'Brain System' will be of practical value."..

*The Science of Chiropractic, by Dr. B. J. Palmer, Vol. II., Pages 60 to 63 inclusive.

There are twelve pairs of cranial nerves. They have been numbered from before, backward, as to their appearance at the base of the brain. They have been named as to function or distribution. They are termed "cranial nerves" because they take their origin in the cranium. Some are motor, some are sensory, and some are mixed—both motor and sensory.

The olfactory (sensory) is so named because its fibers from the olfactory area to the rhinencephalon convey vibrations which are interpreted as the sense of smell; the optic (sensory) is so named because its fibers from the rods and cones at the posterior part of the eyeball, convey vibrations to the visual center of the brain which are interpreted as sight; the oculomotor is so named because it supplies all the extrinsic muscles of the eye, with the exception of two which control the movement of the eyeball; the trochlea (motor) is so named because it goes over a pulley supplying the superior oblique oculi; the trifacial (mixed) is so named because it is divided into three main divisions that supply the face; the abducens (motor) is so named because it supplies the external rectus and abducts the eyeball; the facial (mixed) is so named because it is the main motor nerve of the face, supplying all of the muscles except those of mastication which are supplied by the anterior division of the mandibular nerve of the trifacial—it also has a sensory division; the acoustic (sensory) is so named because it is the nerve of hearing—it has two divisions, one is the cochlea division—the other is the vestibular and is the nerve of equilibration; the glossopharyngeal (mixed) is so named because it gives its main supply to the tongue and pharynx; the vagus (mixed) is so named because it has a wandering distribution; the accessory (motor) is so named because it has an accessory division from the spine, and the hypoglossal (motor) is so named because it is the motor nerve which runs beneath the tongue.

Clinically, all cranial nerves have a spinal connection. However, anatomically, not much is known. For example, the anato-

mist has not made this connection with the acoustic nerve, but its spinal connection was proved clinically when D. D. Palmer adjusted Harvey Lillard, and this was the basis of the discovery of the science of Chiropractic. Since that time we have repeatedly obtained results through other cranial nerves by adjusting the spine.

The medulla oblongata is known as the intra-cranial portion of medulla spinalis. It is the connection of brain with spinal cord. It has located within it many nuclei which are the nuclei of origin or nuclei of termination of many of the cranial nerves.

The brain and the medulla spinalis are covered by three protective membranes, from inward-outward—the pia mater, the arachnoid and the dura mater. The pia mater is very vascular and follows the exact contour of the outer surface of both structures. It is different in the medulla spinalis in that it sends into the medulla spinalis delicate septa. The arachnoid is a web-like or sponge-like membrane. The dura mater is a tough, non-elastic membrane which has two layers in the brain, while in the spinal cord there is only one layer. The outward layer of the brain forming the periosteum of the inside of the skull and the inner layer sending between the structures of the brain partitions which hold the brain in situ, namely: falx cerebri; falx cerebelli; tentorium cerebelli and diaphragma sellae. There are two spaces within the meninges that are filled with fluid. The subdural space between the dura mater and the arachnoid is filled with a fluid in the nature of lymph. The subarachnoid space between the arachnoid and the pia mater is filled with cerebrospinal fluid—the same fluid that is in the ventricles of the brain and in the spinal canal. These three membranes and two spaces afford a protection for the medulla spinalis and brain.

The medulla spinalis, or spinal cord, is the elongated portion of the central nervous system. It extends from the medulla oblongata to a level with the second lumbar vertebra and ends in the conical extremity to which a ligament is attached. This is known as the Filum Terminale, and descends to the second segment of the coccyx. The medulla spinalis has two enlargements, cervical and lumbar, for the accommodation of the large nerves that supply the limbs. Within the center is located the gray substance which has projections, known as cornu, which

gives this gray substance the appearance of a letter "H". The gray substance is largely composed of neuroglia and imbedded within it are many nerve cells which afford a connection for the fibers which convey impulses to and from the brain. It is divided for the convenience of study into funiculi which are subdivided into fasciculi or tracts. In reality these are a continuation of the spinal nerve fibers, as the spinal nerves are considered as taking their origin from the cell within the cornu of the gray substance.

Anatomically, there are located on each side of the medulla spinalis about sixteen fasciculi, namely; The anterior cerebrospinal fasciculus, principally conducting voluntary motor impulses from the precentral gyrus to the motor centers of the cord.

The Vestibulospinal fasciculus makes connection with the vestibulo division of the acoustic nerve and ends either directly or indirectly among the motor cells in the anterior cornu. This fasciculus is probably concerned in equilibration.

The Tectospinal fasciculus arises in the opposite superior colliculus, and ends either directly or indirectly among the motor cells of the anterior cornu, and is probably concerned with the visual reflexes.

The Ventral spinothalamic fasciculus arises in the cells of the posterior cornu and intermediate gray matter, and ends in the thalamus probably concerned with touch.

The anterior proper fasciculus is intersegmental in character.

The lateral cerebrospinal fasciculus arises in the large pyramidal cells in the motor area of the cerebral hemisphere, and ends directly or indirectly around the motor cells of the anterior cornu. It probably conducts motor impulses to associated groups of muscles.

The Rubrospinal fasciculus arises from the red nucleus and ends either directly or indirectly in the cells of the anterior cornu. This fasciculus is supposed to be concerned with the cerebellar reflexes as the red nucleus connects with the cerebellum.

The Dorsal spinocerebellar fasciculus, arises from the cells of the posterior cornu and connects with the cerebellum. It is supposed to conduct impulses of unconscious muscular senses.

The Ventral spinocerebellar fasciculus arises from the cells of the posterior cornu and the intermediate gray matter and terminates in the cerebellum. Other fibers are said to continue upward into the mid brain, probably as far as the thalamus.

The lateral spinothalamic fasciculus arises in the cells of the posterior cornu and the intermediate gray substance and terminates in the thalamus. It is supposed to conduct impulses of pain and temperature.

The spinotectal fasciculus is supposed to arise in the posterior cornu and terminate in the inferior colliculus. Its function is somewhat questionable.

The fasciculus of Lissauer is regarded as being formed by the posterior nerve roots which ascend for a short distance and then enter cells of the posterior cornu. It has both medullated and non-medullated fibers. The non-medullated are thought to be intersegmental and enter into the substantia gelatinosa of Rolando which is located on the apex of the posterior cornu. The substantia gelatinosa is supposed to be concerned with the reflexes associated with pain impulses.

The lateral proper fasciculus is chiefly intersegmental in character. It continues upward into the brain under the name of the medial longitudinal fasciculus. I am of the opinion that this is a connection between the association or intersegmental fibers of the cord and the association fibers of the brain.

The fasciculus cuneatus and the fasciculus gracilis are mostly derived from the posterior nerve roots. They come in close relationship with the dorsal nucleus and end in the gracile and cuneate nuclei. These fasciculi pass through the medial lemniscus to the thalamus and give impulses of several varieties which may be either impulses of conscious muscle sense or impulses of unconscious muscle sense of tactile determination. Their connection with the cortex is through the different stalks of the thalamus.

If these were all of the fasciculi in the medulla spinalis, as described by anatomists, only the functions of these fasciculi would be conveyed to the body. For example: the functions of motor, of equilibrium; touch; pain; temperature; visual reflexes; cerebellar control and intersegmental associations. It is quite ob-

vious that there are other fasciculi which the anatomists have not located that carry on the numerous functions of the body.

The cells which are located in the anterior cornu of the medulla spinalis give origin to the anterior root of the spinal nerve. Located on the posterior nerve root is a ganglion, known as the spinal ganglion, and is the origin of the posterior nerve root. The central processes from the ganglion end around the cells of the posterior cornu, or, as in the case of the fasciculus cuneatus and the fasciculus gracilis, end in the gracile and cuneate nuclei which are analogous to the cells of the cornu. The peripheral processes from the spinal ganglion join the anterior nerve root and form the spinal nerve.

Spinal nerves have been commonly thought of as being of only two types, sensory and motor, but there is a possibility that a spinal nerve is composed of some or all of the different types of fasciculi that exist in the medulla spinalis. A spinal nerve is so named because the anatomist considered it as a group of nerve fibers from the spinal cord to the periphery. However, fibers in these fasciculi are in reality a continuation of fibers which have been termed spinal nerves, so therefore, the real origins or determinations of spinal nerves, cranial nerves and peripheral visceral nerves are in the cortex of the brain.

The spinal nerve emerges through intervertebral foramen and divides into anterior, and posterior divisions. The posterior divisions are short, divided into medial and lateral, supplying structures of back close to spine. The anterior divisions of spinal nerve are quite extensive in distribution. They join together, with the exception of those in thoracic region, and form plexuses known as cervical, brachial, lumbar, sacrum and pudental, which supply anteriolateral part of the body and limbs.

In the study of neurology, naming of structures has been according to either their function, discoverer, or location: i.e., the function of the oculomotor nerve supplying many of the ocular muscles; aqueduct of Sylvius, a canal discovered by the French anatomist Sylvius; the central cerebral fissure, centrally located in each cerebral hemisphere.

The anatomist arranges the nervous system into a cerebro-spinal or central nervous system and sympathetic nervous system. However, there have been more names given to this so-

called SYMPATHETIC NERVOUS SYSTEM than any part of the nervous apparatus. It has been termed the involuntary nervous system; the automatic nervous system and the vegetative nervous system, which indicates that it does not come in the realm of any of the classifications as mentioned above: namely, function, discoverer and location.

It has been said by those whom I consider good authorities that seventy-five per cent of the energy developed in our bodies is under the control of the automatic nervous system, or as we term it, the PERIPHERAL VISCERAL SYSTEM.

I will not attempt to state the percentage of nerve energy that is under the control of this system. The anatomists describe its function as controlling almost all of the viscera of the body.

Why shouldn't the Chiropractic profession give this system a name which really connotes the function of the system? We have named it the PERIPHERAL VISCERAL SYSTEM because it actually describes the function of this branch of the nervous system. Help Chiropractic make history and call it the PERIPHERAL VISCERAL SYSTEM.

The Peripheral Visceral System is part of the nervous system and has been anatomically described as a gangliated cord or trunk that extends from base of brain to tip of coccyx. It enters the cranium through carotid canal and divides into medial and lateral branches, forming the cavernous and carotid plexuses and many other small plexuses which are joined together and connect with trunk of opposite side at anterior communicating artery. Some authorities contend that located at this point is the ganglion of Ribes. In the cervical region, the trunk is located anterior to the transverse processes; in the thoracic, anterior to the heads of the ribs and in the lumbar region, at the side of the bodies of the vertebrae and anterior to the sacrum. At the coccyx, the two trunks are joined together into one ganglion known as the ganglion of Impar.

The preganglionic fibers which enter this gangliated trunk are known as the white rami communicantes. The efferent fibers anatomically originate in the intermedio cells of the lateral cornu; in all of the thoracic region and in the upper three lumbar. These fibers run through the anterior nerve roots and exit

the foramen through the spinal nerve. The afferent fibers anatomically have their origin in the spinal ganglion. The peripheral fibers exit the foramen through the spinal nerve and then run with the efferent fibers to the ganglionic trunk as the white rami communicantes. The central fibers run through the posterior nerve root into the cells of the posterior cornu. Anatomically, there is no fasciculus making connection to the brain, BUT CLINICALLY THERE IS. There are cells that appear in the sacral region which give off preganglionic fibers that are in the same category as the white rami communicantes. They do not enter the gangliated trunk but go directly into the ganglia of the pelvic plexuses. Anatomists state that these cells reappear in the cervical region, but do not give a connection from them. The ganglia of the gangliated trunk give off numerous postganglionic fibers. Anatomically these fibers connect with several of the cranial nerves, but CLINICALLY THERE IS A CONNECTION WITH ALL OF THE CRANIAL NERVES. The cervical ganglia give off carotid branches that enter the carotid plexuses which supplies the heart and also sends fibers into the pulmonary plexuses of the lungs. In the upper thoracic region, the postganglionic fibers also enter the cardiac and pulmonary plexuses. The greater splanchnic nerve is composed of postganglionic fibers from the fifth to the ninth thoracic ganglia. It enters the celiac ganglion of the celiac plexus. The lesser splanchnic nerve is formed from the tenth and eleventh ganglia and joins the aorticorenal ganglion of the celiac plexus. The lowest splanchnic nerve is formed from the last thoracic ganglion and enters the renal plexus. Many of the postganglionic fibers from the gangliated trunk with branches from the vagus nerve, form the three great plexuses of the peripheral visceral system, namely: cardiac, celiac and hypogastric of which there are numerous secondary plexuses which give off peripheral fibers that supply the viscera of the thorax and abdomen. There is a connection between the superior cervical ganglion, the vagus, hypoglossal and glossopharyngeal nerves, and the superior cervical ganglion is connected with the upper four cervical nerves. The postganglionic fibers are given off from all of the ganglia of this gangliated trunk which enter all of the spinal nerves, termed the gray rami communicantes. Their distribution is to the blood vessel walls,

sebaceous and suderiferous glands, etc., etc. Therefore, it might be said that the gray rami communicantes give a supply to the viscera of the somatic. "The sympathetic nervous system REGULATES ALL those many functions of the body, which are normally OUTSIDE OUR KEN AND OUR VOLITION. One of these functions is to regulate the size of the blood vessels and thereby the amount of blood reaching the various parts of the body at any given moment AND UNDER PARTICULAR NEED.

"In certain persons, FOR REASONS NOT UNDERSTOOD, the sympathetic NERVES GET OUT OF CONTROL. They produce more or less continuous spasms of the blood vessels in the hands and feet and a cure can be obtained ONLY BY CUTTING THE NERVES affecting these vessels." — (Copied from an exhibit in the Halls of Science, Chicago World's Fair, 1934.)

The anatomist's terminology indicates the limitation of anatomical findings. Quoting from pages 976 to 982 Gray's Anatomy, Twenty-first Edition:

"The cranial sympathetics include sympathetic efferent fibers in the oculomotor, facial, glossopharyngeal and vagus nerves, as well as sympathetic afferent in the last three nerves.

"The Sympathetic Efferent Fibers of the Oculomotor Nerve PROBABLY arise from cells in the anterior part of the oculomotor nucleus which is located in the tegmentum of the mid-brain. These preganglionic fibers run with the third nerve into the orbit and pass to the ciliary ganglion where they terminate by forming synapses with sympathetic motor neurons whose axons, postganglionic fibers, proceed as the short ciliary nerves to the eyeball. Here they supply motor fibers, to the Ciliaris muscle and the Sphincter pupillae muscle. SO FAR AS KNOWN there are no sympathetic afferent fibers connected with the nerve.

"The Sympathetic Efferent Fibers of the Facial Nerve are SUPPOSED to arise from the small cells of the facial nucleus. According to some authors the fibers to the salivary glands arise from a special nucleus, the superior salivatory nucleus, consisting of cells scattered in the reticular formation, dorso-medial to the facial nucleus. These preganglionic fibers are distributed partly through the chorda tympani and lingual nerves to the submaxillary ganglion where they terminate about the cell bodies of

neurons whose axons as postganglionic fibers conduct secretory and vasodilator impulses to the submaxillary and sublingual glands. Other preganglionic fibers of the facial nerve pass via the great superficial petrosal nerve to the sphenopalatine ganglion where they form synapses with neurons whose postganglionic fibers are distributed with the superior maxillary nerve as vasodilator and secretory fibers to the mucous membrane of the nose, soft palate, tonsils, uvula, roof of the mouth, upper lips and gums, parotid and orbital glands.

"There are SUPPOSED to be a few sympathetic afferent fibers connected with the facial nerve, whose cell bodies lie in the geniculate ganglion, BUT VERY LITTLE IS KNOWN ABOUT THEM.

"The Sympathetic Afferent Fibers of the Glossopharyngeal Nerve are SUPPOSED to arise either in the dorsal nucleus (nucleus ala cinerea) or in a distinct nucleus, the inferior salivatory nucleus, situated near the dorsal nucleus. These preganglionic fibers pass into the tympanic branch of the glossopharyngeal and then with the small superficial petrosal nerve to the otic ganglion. Postganglionic fibers, vasodilator and secretory fibers, are distributed to the parotid gland, to the mucous membrane and its glands on the tongue, the floor of the mouth, and the lower gums.

"Sympathetic Afferent Fibers of the Glossopharyngeal whose cells of origin lie in the superior or inferior ganglion of the trunk, are SUPPOSED to terminate in the dorsal nucleus. VERY LITTLE IS KNOWN of the peripheral distribution of these fibers.

"The Sympathetic Efferent Fibers of the Vagus Nerve are SUPPOSED to arise in the dorsal nucleus (nucleus ala cinerea). These preganglionic fibers are all SUPPOSED to end in sympathetic ganglia situated in or near the organs supplied by the vagus sympathetics. The inhibitory fibers to the heart PROBABLY terminate in the small ganglia of the heart wall especially the atrium, from which inhibitory postganglionic fibers are distributed to the musculature. The preganglionic motor fibers to the esophagus, the stomach, the small intestine, and the greater part of the large intestine are SUPPOSED to terminate in the plexuses of Auerbach, from which postganglionic fibers

are distributed to the smooth muscles of these organs. Other fibers pass to the smooth muscles of the bronchial tree and to the gall-bladder and its ducts. In addition the vagus IS BELIEVED TO CONTAIN secretory fibers to the stomach and pancreas. It PROBABLY contains many other efferent fibers than those enumerated above.

"Sympathetic Afferent Fibers of the Vagus, whose cells of origin lie in the jugular ganglion or the ganglion nodosum, PROBABLY terminate in the dorsal nucleus of the medulla oblongata or according to some authors in the nucleus of the tractus solitarius. Peripherally the fibers are SUPPOSED to be distributed to the various organs supplied by the sympathetic efferent fibers.

"The Sacral Sympathetic Efferent Fibers leave the spinal cord with the anterior roots of the second, third and fourth sacral nerves. These small medullated preganglionic fibers are collected together in the pelvis into the nervus erigentes or pelvic nerve which proceeds to the hypogastric or pelvic plexuses from which postganglionic fibers are distributed to the pelvic viscera. Motor fibers pass to the smooth muscle of the descending colon, rectum, anus and bladder. Vasodilators are distributed to these organs and to the external genitalia, while inhibitory fibers probably pass to the smooth muscles of the external genitalia. Afferent sympathetic fibers conduct impulses from the pelvic viscera to the second, third and fourth sacral nerves. Their cells of origin lie in the spinal ganglia.

"The thoracolumbar sympathetic fibers arise from the dorsolateral region of the anterior column of the gray matter of the spinal cord and pass with the anterior roots of all the thoracic and the upper two or three lumbar spinal nerves. These preganglionic fibers enter the white rami communicantes and proceed to the sympathetic trunk where many of them end in its ganglia, others pass to the prevertebral plexuses and terminate in its collateral ganglia. The postganglionic fibers have a wide distribution. The vasoconstrictor fibers to the blood vessels of the skin of the trunk and limbs, for example, leave the spinal cord as preganglionic fibers in all the thoracic and the upper two or three lumbar spinal nerves and terminate in the ganglia of the sympathetic trunk, either in the ganglion directly connected with

its ramus or in neighboring ganglia. Postganglionic fibers arise in these ganglia, pass through gray rami communicantes to all the spinal nerves, and are distributed with their cutaneous branches, ultimately leaving these branches to join the small arteries. The postganglionic fibers do not necessarily return to the same spinal nerves which contain the corresponding preganglionic fibers. The vasoconstrictor fibers to the head come from the upper thoracic nerves, the preganglionic fibers end in the superior cervical ganglion. The postganglionic fibers pass through the internal carotid nerve and branch from it to join the sensory branches of the various cranial nerves, especially the trigeminal nerve; other fibers to the deep structures and the salivary glands PROBABLY accompany the arteries.

"The postganglionic vasoconstrictor fibers to the bloodvessels of the abdominal viscera arise in the prevertebral or collateral ganglia in which terminate many preganglionic fibers. Vasoconstrictor fibers to the pelvic viscera arise from the inferior mesenteric ganglia.

"The pilomotor fibers to the hairs and the motor fibers to the sweat glands apparently have a distribution similar to that of the vasoconstrictors of the skin.

"A vasoconstrictor center has been located by the physiologists in the neighborhood of the facial nucleus. Axons from its cells are SUPPOSED to descend in the spinal cord to terminate about cell bodies of the preganglionic fibers located in the dorso-lateral portion of the anterior column of the thoracic and upper lumbar region.

"The motor supply to the dilator pupillae muscle of the eye comes from preganglionic sympathetic fibers which leave the spinal cord with the anterior roots of the upper thoracic nerves. These fibers pass to the sympathetic trunk through the white rami communicantes and terminate in the superior cervical ganglion. Postganglionic fibers from the superior cervical ganglion pass through the internal carotid nerve and the ophthalmic division of the trigeminal nerve to the orbit where the long ciliary nerves conduct the impulses to the eyeball and the dilator pupillae muscle. The cell bodies of these preganglionic fibers are connected with fibers which descend from the mid-brain.

"Other postganglionic fibers from the superior cervical gang-

lion are distributed as secretory fibers to the salivary glands, the lacrimal glands and to the small glands of the mucous membrane of the nose, mouth and pharynx.

"The thoracic sympathetics supply accelerator nerves to the heart. They are SUPPOSED to emerge from the spinal cord in the anterior roots of the upper four or five thoracic nerves and pass with the white rami to the first thoracic ganglion, here some terminate, others pass in the ansa subclavia to the inferior cervical ganglion. The postganglionic fibers pass from these ganglia partly through the ansa subclavia to the heart, on their way they intermingle with sympathetic fibers from the vagus to form the cardiac plexus.

"Inhibitory fibers to the smooth musculature of the stomach, the small intestine and most of the large intestine are SUPPOSED to emerge in the anterior roots of the lower thoracic and upper lumbar nerves. These fibers pass through the white rami and sympathetic trunk and are conveyed by the splanchnic nerves to the prevertebral plexus where they terminate in the collateral ganglia. From the celiac and superior mesenteric ganglia postganglionic fibers (inhibitory) are distributed to the stomach, the small intestine and most of the large intestine. Inhibitory fibers to the descending colon, the rectum and internal sphincter ani are PROBABLY postganglionic fibers from the inferior mesenteric ganglion.

"The thoracolumbar sympathetics are characterized by the presence of numerous ganglia which may be divided into two groups, central and collateral.

"The central ganglia are arranged in two vertical rows, one on either side of the middle line, situated partly in front and partly at the sides of the vertebral column. Each ganglion is joined by intervening nervous cords to adjacent ganglia so that two chains, the sympathetic trunks, are formed. The collateral ganglia are found in connection with three great prevertebral plexuses, placed within the thorax, abdomen, and pelvis respectively."*

*Gray's Anatomy, Twenty-first Edition, pages 976 to 982.

The function of the body is under a definite control of the nervous system. It controls the action of the heart; the opening and closing of the valves; the act of respiration; the expansion and

contraction of the lungs; the exchanging of oxygen for carbon dioxid through the membranes of the lungs; the peristalsis of the stomach; the secretion of the enzymes for digestion; the function of the liver as a chemical laboratory in gathering the residue from the blood stream and reconverting it into materials which may be used elsewhere in the body; the function of the endocrine glands; the function of the kidneys as a filter for the blood stream; the regulation of the body temperature; etc., etc. Without this control which the nerve system carries on, there could not be life. An interference with this nerve force, which is the source of life, will deplete life in direct ratio to the interference.

There is a cortical center for every function; that is, there is a portion of the cerebral cortex which is directly connected with every tissue cell of the body. If a certain portion of the cortex was destroyed, the tissue cells that are connected with this portion of the cortex would not function. Also if there was pressure interfering with the normal flow of mental impulse from the cortex to the tissue cell, life would be depleted in ratio to pressure.

There is a direct continuity between brain cell and tissue cell; that is, there is only one path by which nerve force can get through. There are no detours or by-passes or anastomoses of nerves for mental impulses. If there is an obstruction in this path, it is obvious that life will be depleted in the same percentage as the percentage of obstruction.

A mental impulse is through a cycle efferent and afferent. Efferently, the mental impulse comes from the brain and afferently there is an interpretation in the brain that controls the quantity and quality of the efferent impulse. In the past, the motor fibers have been given as the efferent, and the sensory fibers as the afferent. I am of the opinion that we have both efferent and afferent in the motor and both efferent and afferent in the sensory and that these two cycles may work together to form another cycle which in the past has been classified as mentioned above, the efferent and afferent; that is, there may be individuals whose motor function is normal but have no sensory function due to nerve pressure, and there are those individuals whose sensory function is normal but are suffering with motor paralysis, so therefore, the motor must have an efferent and an affer-

ent, and the sensory must have an efferent and an afferent. The efferent and the afferent may be over the same nerve.

The nerves are supplied with mental impulses from the nervi nervorum. I do not believe that this comes directly from the nerve which it supplies, but may run through the nerve trunk. This is a separate system that has a cortical center. If the nerve supply came from the nerve which it supplies, the motor nerves would have only a motor supply, and the sensory nerves would have only a sensory supply, which is not the case.

The location of the fibers that are subject to pressure which supply the entire body, either directly or indirectly, are in the medulla spinalis in the region of the Atlas and Axis. All spinal nerves have a direct continuity through this location to their cortical center. The fasciculus which connects the peripheral visceral system with its cortical center goes through this location. The portion of the peripheral visceral system, which connects with all the cranial nerves and the brain, re-enters the cranium through the carotid canal.

Clinically, a pressure in region of Atlas and Axis may affect any or all functions. An abnormal position of Atlas and Axis may cause pressure on spinal nerves that exit in this location because nerve filaments that exit from medulla spinalis to form a spinal nerve are over some slight width equivalent to a neuromere. Also spinal nerves are very close to the surface in region of their exit, so therefore, it is quite impossible to have pressure on medulla spinalis without causing a pressure on spinal nerves that exit from that location. The Neurocalometer determines when this pressure is present and thus becomes a scientific guide as to when and when not to adjust.

The peripheral visceral system is not the same in all individuals. The fibers that help to form this ganglionic trunk may go up or down the trunk some distance before they enter a ganglion and the afferent portion may not necessarily return to same ganglion as origin of the efferent. Many fibers of this system cross in the commissures of the medulla spinalis. From a neurological view, might it not be possible that some of the mean line readings may be caused by interference on fibers running in this ganglionic trunk, this ganglionic trunk being located directly in the path of the terminals of the Neurocalometer? Some of the

Neurocalometer mean line readings are checked out many times by an adjustment.

From a neurological view, the building of an adjustor is the building of the brain. As there is a cortical center for every function, the cortical center of the muscles that we use in adjusting must be developed. The repeated practice of the adjustic move is not to build the muscles in particular, but is to build that portion of the brain that controls the muscles. The musician in his practice is building his brain. The sculptor mentally sees in the rugged boulder the finished product, and the building of his brain guides the mallet and chisel until it becomes an object of aesthetic beauty to others. The training of an aviator is for the purpose of building the brain so that in time of need he may do things in an Innate way that may protect his life and the life of others. Therefore, it is quite obvious that if our thoughts are constructive, our actions will be constructive. We in the process of training are actually building what might be termed a Chiropractic brain or it may be termed our library for future reference. The building of any structure is equivalent to the material used. If we focus our thoughts upon Chiropractic questions and fundamentals, then in the time of need, we may draw from this source which will assist us in delivering Chiropractic service. If our thoughts are contaminated with material that would tend to weaken Chiropractic structure, our service to suffering humanity may be limited to a great degree, because the things that were used in the building of the structure, were contrary to Chiropractic principles.

There has been a gradual focusing of all branches of the Chiropractic profession to the specific for the cause of all diseases. The Neurocalometer has guided this focusing to Atlas and Axis region. Spinograph and study of Osteology have revealed that it is the only possible region where a subluxation can exist, and Neurologically, is the only region where there can be pressure that may affect all functions of the body.

CHAPTER VII.

LOCATING THE SPECIFIC



THE SPECIFIC CAUSE for the presence of ALL dis ease, regardless of whether it be brain congestion above or body starvation because of an absence below, lay somewhere between the brain and body. This SPECIFIC was finally located somewhere in region of the superior three cervical vertebrae. Close below the brain and close above the body was a vertebral subluxation occluding a spinal canal and producing pressure upon the spinal cord making it impossible for energy to get from the brain down into all parts of the body. Dis-ease existed below because of the absence of a normal quantity to produce ease.

The PRINCIPLE of "cord pressure" was laid down in Vol. 3 in 1906. The practice of it began then. WHEN to apply it, in what cases, etc., was entirely problematical, hypothetical, and accidental. The new question of kink, twist, wrench or torque as to WHY it is important AS THE MECHANICAL CAUSE AND LOCATING FACTOR OF THIS "CORD PRES-SURE," as now combined, is a practical reason more than presented before.

The HIO principle was born when this portion of the dis-ease problem had been solved.

It was with fear and trepidation, and with no little courage, that we struck forth on unbeaten areas to see if that principle was sound; whether it worked in practice, notwithstanding all have had cases that pointed the way, thruout years past, yet none had courage sufficient to follow thru to its ultimate logical conclusion. It took conviction to approach a group of cases and CONFINE THE ADJUSTMENT EXCLUSIVELY TO THOSE REGIONS to see exactly whether PRACTICE would sustain PRINCIPLE. After many cases had been clinically observed under this EXCLUSIVE process, the practice WAS found to sustain the principle. It was in the fall of 1930 that the practice was publicly advanced to our profession with the hope that it would be given a fair and just trial to see if what we had found was

true in other instances, with other people, in other lands, and could be established as a universal truth.

Gradually the profession has approached the new idea. Chiropractors have exclusively confined adjusting to that region, regardless of conditions cases may have been suffering with; regardless of location effects were located in. It was a bold step from general adjusting to major adjusting; it was bolder to advocate one specific adjustment, at one place, for all cases, in preference to major adjusting at a few places determined by the meric system.

Between the spring of 1930 and the fall of 1933, thousands of cases have been exclusively adjusted by the HIO major confined in the superior cervical vertebral region, with one adjustment, one place, one direction, consistently. (See Analysis in Adenda at rear of book.)

Thousands of cases have been adjusted with results reported attained in greater percentage of worse types, in quicker time than under any known previous system within our history.

To attain this end, Chiropractors were asked to confine their adjustment

- to this region; nowhere else
- to adjust only when a subluxation, in fact, was present
- to adjust only when there was interference present
- to not adjust anywhere else, regardless of whether evidence of past educations seemed to direct attention to other places, in other ways.

To further attain this end, it was further essential that Chiropractors

- not adjust in this or any other region when a subluxation, in fact, was not present
- when there was no interference present
- regardless of what evidences seemed to direct attention to some other locality.

To ascertain the deciding factor, in information upon which action depended, it became more important that Chiropractors use the NCM as THE SOLE AND EXCLUSIVE GUIDE to determine WHEN interference was or was not present; to use SPGH to prove direction of subluxation ascertained at location of interference; and to use only that kind of an adjustment with

that extra something with staying-put value to correct its malposition.

(How well this solution of our problem has been exclusively used, as a profession, is problematical. Many Chiropractors are following its strictest interpretation. Many are trying to do so but slip backward into what they once knew and once used. Others think they are using it, but continue to do today what they did yesterday with its complexities. It is needless to say, that no one can ever arrive at a truthful understanding who mixes one system with accidents occasionally with a desire to specifically know.)

To PROVE that there WAS one exacting, definite, positive SPECIFIC for the cause of ALL dis-ease and that it was located exclusively in the superior three cervical vertebrae, then, required:

- the NCM to locate the presence or absence of interferences and locality of same.
- to check accurately and truthfully, by the exclusive process, what happened to all other interferences in the balance of the spine as well as what happened to all symptoms, pathologies, histories, and diagnoses in the balance of the body.
- use NCM to determine whether or not an adjustment has or has not restored transmission of mental impulse supply.
- the SPGH to prove abnormal position of vertebra subluxated, when it was a subluxation in fact.
- to use the adjustment with that extra something with staying-put value to correct it.
- and, to use that adjusting posture as best made it most easy to accomplish the desired objective.

When all elements were properly, intelligently, efficiently, competently, correctly, and honestly applied, the result was we proved that ANY AND ALL CASES, REGARDLESS OF HISTORY, SYMPTOMS, PATHOLOGY, OR DIAGNOSES; REGARDLESS OF ORGAN OR ORGANS INVOLVED ANYWHERE IN THE HUMAN BODY, COULD AND DID GET WELL BY CONFINING THE ADJUSTMENT ACTION TO

(See list of diseases at rear of this book in An Analysis of HIO Scientific Application of Specific Chiropractic in 5,000 Cases.)

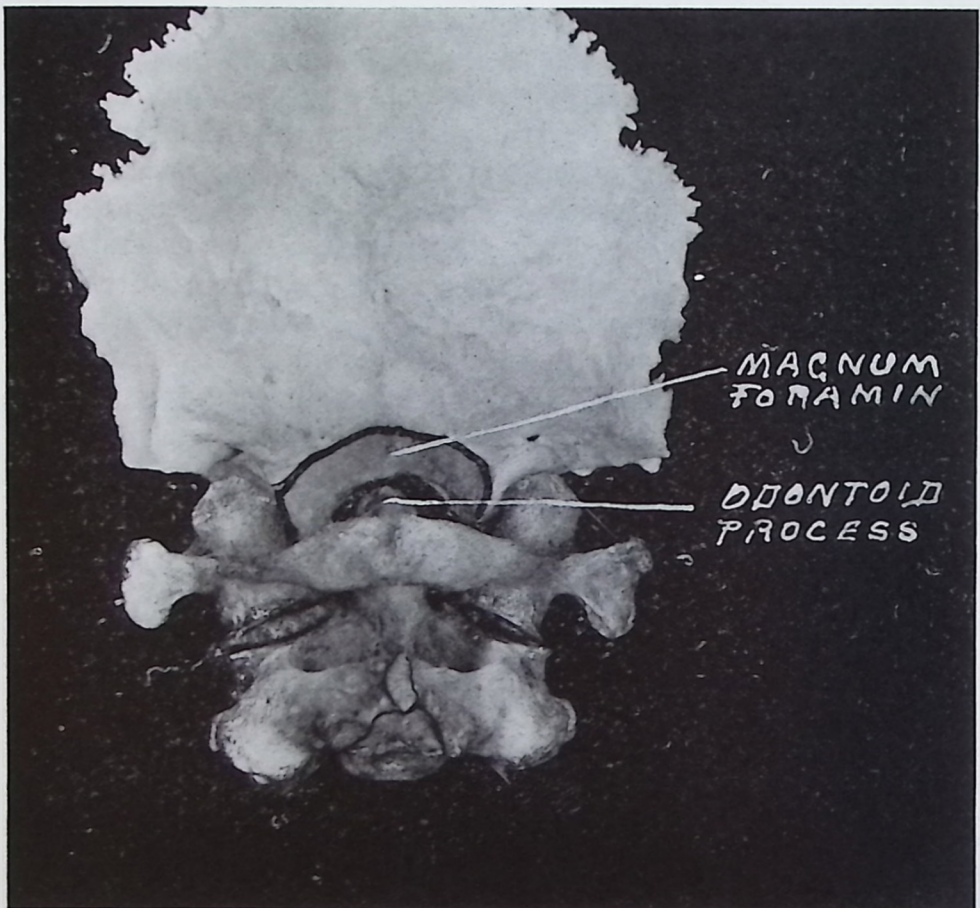


Illustration No. 22

THIS SPECIFIC AREA, exclusive of trauma as applied in general terms.

If the hypothesis is true, and worked, that the ONLY subluxation causing interference is in cervical region, in a spinal column, then it eliminates the possibility of a vertebral subluxation creating interference in any other place in the spinal column. Facts and evidence justify the POSITIVE statement that: NO vertebral subluxation CAN exist below axis; therefore no adjustment with any DIRECT INTENTION OR DESIGN could be given below an axis, to get sick people well.

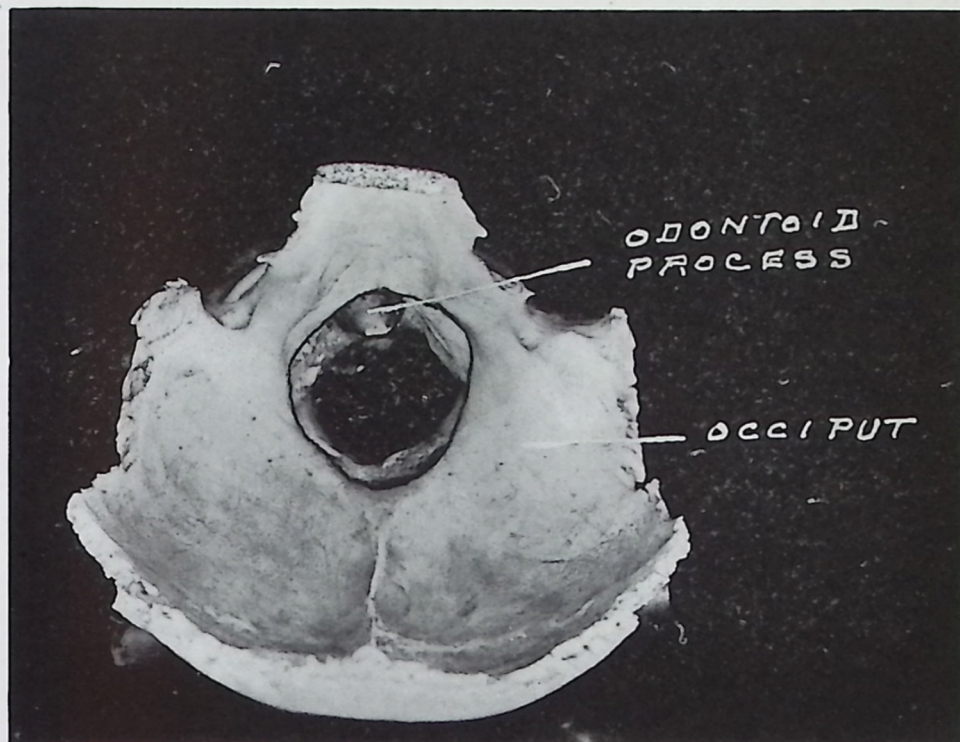


Illustration No. 23

Illustration No. 22.

Posterior view of atlas, axis, and occiput; looking at occiput from rear. This view shows magnum foramen superior to neural canal of atlas and axis. Shows odontoid process passing thru atlas, pointing directly up INTO foramen magnum. The average person little realizes that odontoid process is INSIDE the ring that composes neural canal that begins at magnum foramen above and extends downward into and thru atlas and axis.

Illustration No. 23.

Occiput has been removed from balance of skull. Looking from superior to inferior, from inside of occiput, downward thru neural canal. Posterior superior rim of atlas can be seen on inside of and below occipital rim of magnum foramen. Odontoid process is seen on inside of and on anterior of occipital rim of magnum foramen, as it extends itself upward and thru fovea dentalis of atlas.

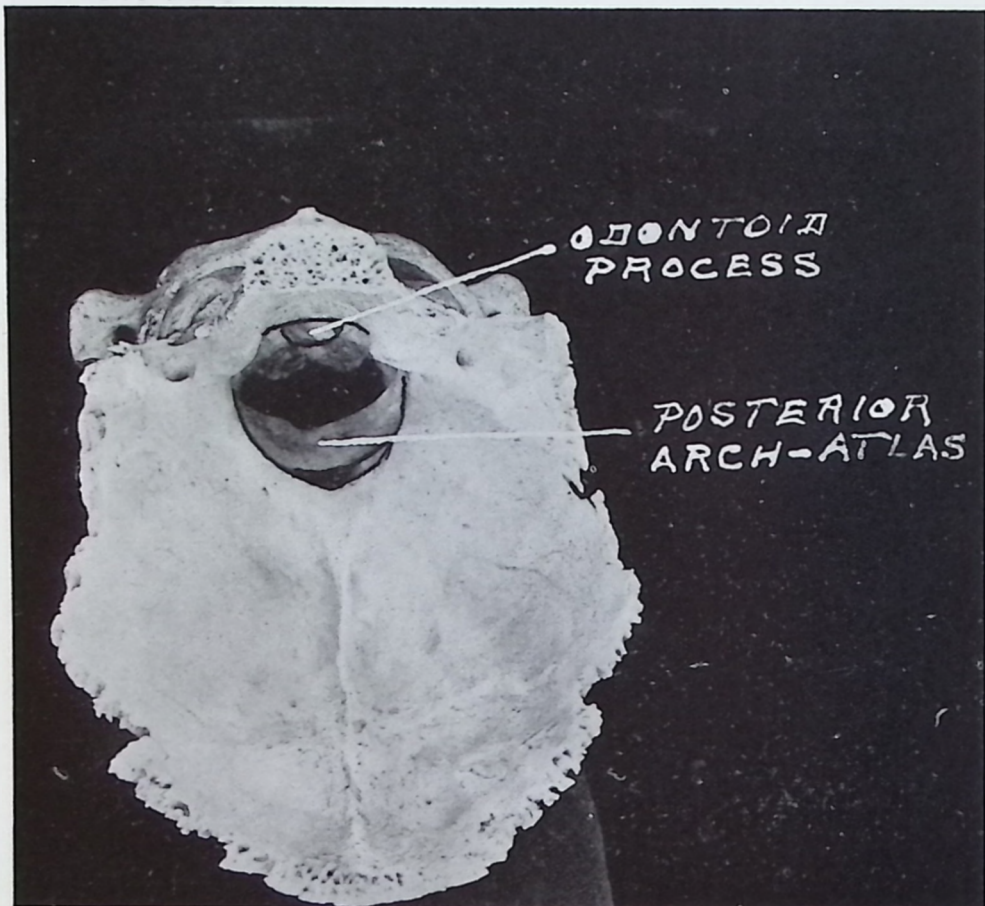


Illustration No. 24

Illustration No. 24.

Occiput has been removed from base of skull. Looking from superior to inferior, from inside of occiput downward thru neural canal. Atlas is subluxated anterior and superior. Anterior arch of atlas can be seen on anterior of occiput. Posterior arch of atlas subluxated anterior and superior, can be seen on posterior of occipital rim. Anterior arch being superior and anterior, automatically throws posterior arch of atlas posterior and inferior, bringing it INTO neural canal, producing occlusion not only between posterior inferior of magnum foramen and superior posterior rim of atlas, but also between posterior inferior rim of posterior arch of atlas and posterior superior rim of posterior

arch of axis. Note how much smaller neural canal is because of this occlusion produced by an anterior superior subluxation of atlas.

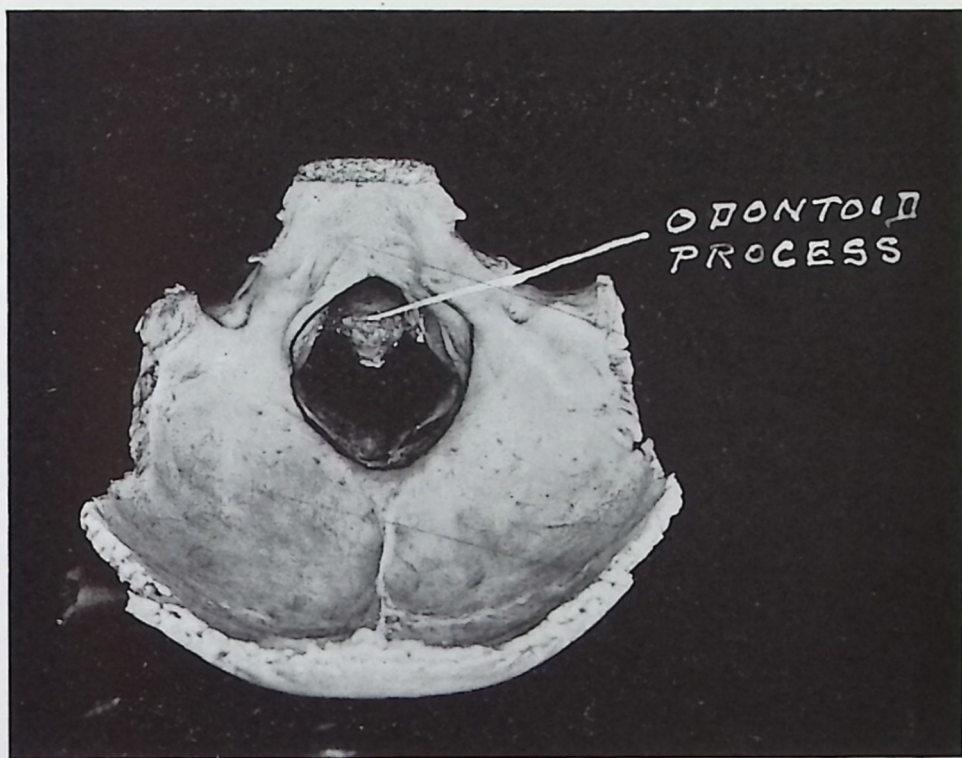


Illustration No. 25

Illustration No. 25.

Occiput has been removed from balance of skull. Looking from superior to inferior, from inside of occiput, downward thru neural canal. Axis is subluxated posterior and inferior. Odontoid process of axis can be seen protruding itself posterior into neural canal. Extending as it does, upward into and thru anterior arch of atlas; extending upward and directly into neural canal; subluxated posterior and inferior as axis is, throws odontoid process posterior directly into the path of spinal cord on its downward passage thru neural canal between occiput and atlas.

PARADOXICAL SUBLUXATIONS

1. People can have a vertebral subluxation—and be sick.
2. People can have a vertebral subluxation—and feel fine.
3. People can have no vertebral subluxation—and feel fine.
4. People can have no vertebral subluxation—and be sick.

It is easy for Chiropractors to understand first and third statements, viz., that WITH a subluxation a person can be sick; and WITHOUT one, can be well. But the reverse is hard to understand. Interval of TIME makes difference.

Let us analyze second statement. A subluxation may occur at 6:00 A.M., January 1st. It might be days, weeks, or months before an acute or chronic condition GROWS gross enough to make manifest its existence to the educated mind of the case. A tumor might be months gradually growing, before it becomes noticeable. Meanwhile case does not know he is sick—feels fine.

Let us analyze fourth statement. Adjustment might be given at 6:00 A.M., June 1st. One adjustment corrects subluxation. Two minutes later, NO subluxation exists. The tumor that has taken six months to grow still exists, and more than likely will exist until tumor UNGrows, which might take months, weeks. The case can be and would feel sick, and yet NO subluxation exists.



Illustration No. 50

Illustration No. 50.

A-P natural. Patient assumed natural prone position. Spino-graph reveals right high wedge-side-slip subluxation. Not marked or exaggerated, but observable. Head leans left. Axis spinous process is right of median line. In this view head is high on right, occiput is low on right, atlas is high on right, axis spinous process is right of median line.

Illustration No. 51.

A-P view. Same case as Illustration No. 50. We asked case to force position of head as much TO RIGHT as possible. We still have a right side-slip but it now APPEARS to be a right LOW wedge-side slip. Head is low on right, occiput is low on right, atlas is high on right. Point of wedge is to right, blunt end to left. Right LOW wedge-side-slip exhibited in THIS view is exaggerated far more than in Illustration No. 50. Left portion of atlas is more removed from occiput in No. 51 than it is in No. 50. In No. 50 it is a right HIGH. Forced strained position makes it a right LOW. Compare carefully marked change in position of axis. In No. 50 it is right of median line. In No. 51 it is left and appears superior. No. 51 appears as tho, by position of axis, head has been rotated. This is not true. Forced laterality of throwing head to right shoulder changed its position accordingly. That forcing head to right has NOT changed right wedge-side-slip, is apparent. That it HAS changed from a right high to right low, is obvious. In No. 50 we have the normal adaptative or compensatory right curve of balance of cervical region. In No. 51, cervical region is approximately straight, brot about by forced change in tilting of head to right.

Illustration No. 52.

A-P view. Same case as Illustrations Nos. 50 and 51. Case was asked to force position of head as much TO LEFT as possible. Right wedge-side-slip apparent in No. 50 is not now apparent. From all angles and measurements, there appears little, if any, side-slipping wedge-shape in position of atlas with occiput. Plane lines would run approximately parallel, showing that forced position of head TO side of natural wedge-side-slip right high in No. 50 has been forced out by forcing head to left. Forcing head to left has made marked additional change in position of

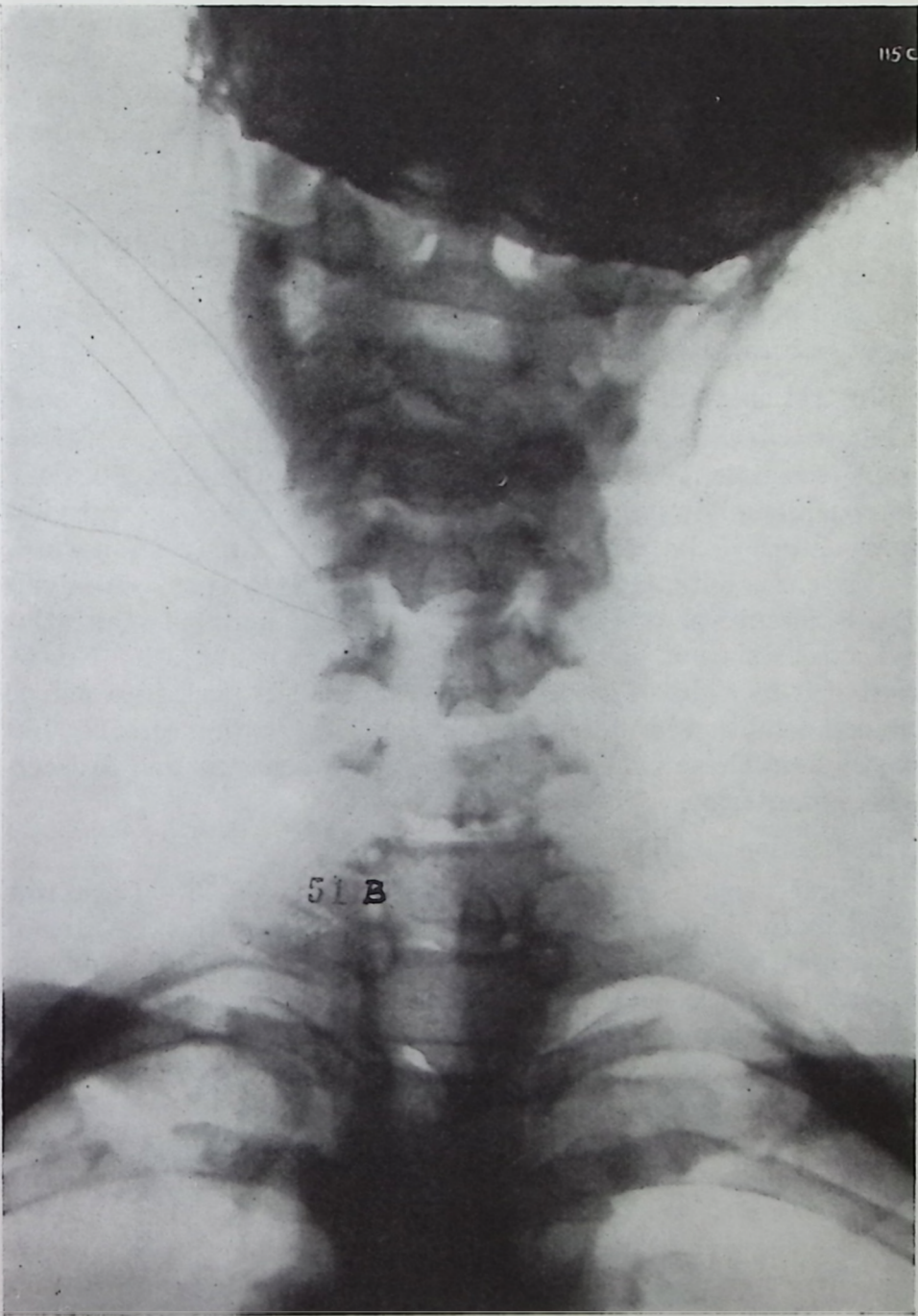


Illustration No. 51

axis. It is not only left of median line, as in No. 50, but has been markedly increased left and apparently superior, giving it appearance of an axis left superior. Distance between axis and 3rd; 3rd and 4th on right, has been forced into a greater separation, lending additional appearance of rotation which there was not. That forcing head to left HAS changed right high wedge-side-slip (No. 50) out of picture, is apparent. That it has shifted interpretation from atlas right high wedge-side-slip to apparent axis subluxation is equally obvious. Offering this proof is evidence of necessary care in positioning cases for spinographs to get natural truth revealed.

Illustration No. 53.

Lateral view. Same case as Illustrations 50, 51, and 52. Spinograph was taken naturally. In conjunction with No. 50 (A-P view) which shows right high wedge-side-slip atlas, lateral view shows atlas to be anterior superior (AS). Analysis, normal, of this case, joining 50 and 53, would be ASR atlas. Analysis of this picture shows no abnormal misalignment between atlas and axis; axis not being involved on lateral view altho No. 50 showed it to right of median line. Odontoid is back into neural canal, a condition brot about not entirely by position of atlas, but mostly so. There is slight separation between axis and 3rd cervical, on anterior.

Illustration No. 54.

Lateral view. Same case as Illustrations 50-53. Case was asked to force head forward to extreme possibilities. Anterior of occiput has decreased distance between it and atlas on anterior. Compare with 53 and note difference in distance. Space between inferior of atlas and axis, on anterior, has materially decreased. In spite of this change, atlas is still recognizable as an anterior superior (AS). Position of odontoid in neural canal has not changed. Distance between anterior arch and odontoid process remains about same. No. 53 shows a consistent separation between centra of all cervical vertebrae, in normal. No. 53 shows all spaces closed, on anterior. Forced anterior position has been absorbed by all vertebrae, no one taking up all the slack. Tube distance was same in both views. Tube was centered as near same center for 54 as for 53, yet it seemingly looks



Illustration No. 52

as tho it were centered inferior to and looking upward thru posterior arch of atlas, making posterior arch and atlas appear as tho lifted upon one side, or lowered on other. This is due to right high wedge-side-slip noted in natural position of No. 50. One thing this view brings prominently to attention is compression of occiput onto atlas and atlas onto axis.

Illustration No. 55.

Lateral view. Same case as 50-54. Case was asked to force head backward. All three lateral views were taken sitting. Anterior of occiput has increased distance between it and atlas on anterior, and decreased distance between it and atlas on posterior. Compare with 53 and note difference in distance. Space between inferior of atlas and axis, on posterior, has materially decreased. In fact, all cervical centra have separated on anterior and all spinous processes are crowding each other on posterior. In spite of these changes, atlas is recognizable as anterior superior (AS). Position of odontoid process in neural canal has not changed. Distance between anterior arch and odontoid process remains about same. Forced posterior position has been absorbed by all vertebrae, no one taking up all the slack. This view brings some difference in superiority on one side and inferiority on other side, to view; but not as much so as 54. This is due to the fact that no matter how much you force the vertebra into an abnormal position, subluxation still retains subluxated position, which in this case was a right high wedge-side-slip anterior and superior.

Illustration No. 56. Same case as Illustrations 50-55.

Case ROTATED head to right. Case did not lean head over shoulder. Case did not turn head to straining position. Objective was to ascertain what ROTATION did to changing of position of vertebrae, showing that distortion COULD BE made artificially. Same case was used because she had an atlas right high wedge-side-slip subluxation and we wanted to see what changes occurred when any other than natural position was assumed. Follow the line of spinous processes; note they change from median line to right, with same rotation. Most rotation took place between atlas and axis. Study carefully distortion between inferior zygapophyses of atlas and axis, how they are off articu-



Illustration No. 53

lation on both left and right. Rotation takes out right high and does not create a right low.

Illustration No. 57. Same case as Illustrations 50 to 56.

Case ROTATED head to left. Case did not lean head over on shoulder. Neither did she strain position. 56 shows cervical region comparatively straight. 57 shows a decided break in comparative straight line. Study of articulations between atlas and axis shows them together and not separated as in 56. Comparison of spinous process line shows them more to right in 57 than in 56. This change occurs because of case having right high wedge-side-slip which prevented as much movement to left in 57 as was to right in 56. This view portrays existence of right high wedge-side-slip.

Illustrations 58 and 59. Same case as Illustrations 50 to 57.

Case was in knee-chest adjusting posture. Head properly and correctly placed on superior portion of adjusting table. Tube was placed at right angles to slope of neck on adjusting table to eliminate distortion due to ray-deflection. 58 head was turned to left, face down on right side. 59 head was turned to right, face down on left side. Both views indicate deflection of position of cervical vertebrae which have raised on one side, or apparently lowered on other. Both views show outlines of condyles in articulation with atlas.

Conclusions:

The two natural views, No. 50 (A-P) and 53 (Lateral) prove an ASR right high wedge side-slip subluxation. The forced position of head to right changed R high to a R low, but did not change the side-slip subluxation. The forced position of head to left brot occiput and left portion of atlas together sufficiently, and forced them apart on right sufficiently to take out evidence of wedge so that it is difficult to tell whether there is a point or blunt end; but while we have that change, the side-slip to right still remains. Forced anterior and posterior views did not change essentials to make it other than an AS. Exaggeration of position of axis could be discounted in forced pictures, because it was not considered major in the beginning.

Rotation to right took out right high wedge-side-slip but did

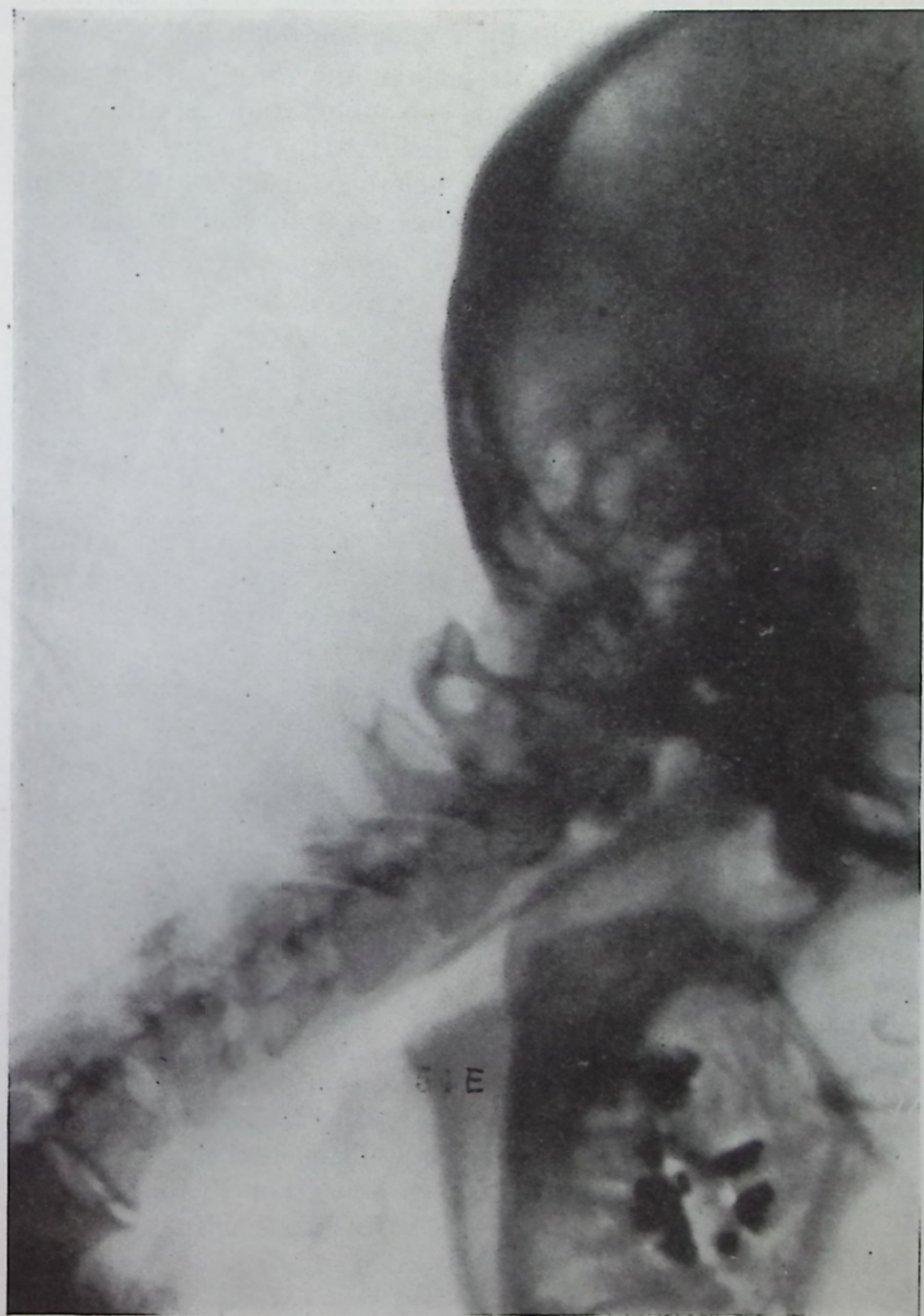


Illustration No. 54

not change it to any other position. Rotation to left continued to portray existence of right high wedge-side-slip.

To carry research further, we took another group of ten views of each of three major wedge-side-slip subluxations of atlas. We put each set through same ten distorted, perverted, strained positions to see if same conditions held good. We state in detail what was found in each of two other right high instances.

Study of Set B of forced changed positions reveals:

A-P natural. Right high wedge-side-slip of atlas.

Lateral natural. Anterior and superior (AS).

The basis of study is ASR right high wedge-side-slip.

Head bent to extreme to left and over shoulder.

Changed right high to left low.

Head bent to extreme to right and over shoulder.

Made right high appear approximately normal.

Head bent backwards, in extreme. Lateral view.

Is still anterior superior (AS).

Head bent forward, in extreme. Lateral view.

Is still anterior superior (AS).

Head turned left rotated, slightly inferior on left. A-P view.
Atlas appears right high.

Head turned right rotated, slightly inferior on right. A-P.
view.

Atlas appears left high.

Head and body down in adjusting position. Right face down.

Head and body down in adjusting position. Left face down.

Hard to tell whether down side is high or low, on either side. But in both views, one side IS down and other IS up, showing what adjusting position does to atlas in prone adjusting knee-chest position.

Summary: We have a right-high-wedge-side-slip.

Listing ASR.



Illustration No. 55

Bending head low on left side changes right high to left low.

Bending head low on right side made right high appear approximately normal.

Bending forward and backward, forced bend does not change AS except in degree.

Rotating head left makes atlas right high.

Rotating head right makes atlas left high.

Head and body down in adjusting position makes atlas high on one side and low on other. It is difficult to tell which, for same reason as stated with Set C of forced changed positions.

Study of Set C of forced changed position reveals:

A-P natural. Right high wedge-side-slip.

Lateral natural anterior and superior (AS).

The basis of study is ASR right high wedge-side-slip.

Head bent to extreme to left and over shoulder.

Changed right high to left low.

Head bent to extreme to right and over shoulder.

Changed right high to right low.

Right condyle is side-slipped TO LEFT in both views.

Head bent backwards, in extreme. Lateral view.

Is still anterior superior (AS).

Head bent forwards, in extreme. Lateral view.

Is still anterior superior (AS).

Head rocked on atlas, forward and backward, but atlas retains anterior-superior position (AS), more where head is rocked posterior, less where rocked anterior.

Head turned left-rotated, slightly inferior on left. A-P view.
Atlas appears right high.

Head turned right-rotated, slightly inferior on right. A-P view.
Atlas appears left high.



Illustration No. 56

Right high is more pronounced than left high.

Right condyle is side-slipped TO LEFT in both views.

Head and body down in adjusting position. Right face down.

Head and body down in adjusting position. Left face down.

Hard to tell whether down side is high or low on either side. But in both views, one side IS down and other IS up, showing what adjusting position does to atlas in prone adjusting knee-chest position.

Summary: We have a right high wedge-side-slip.

Listing ASR.

Bending head low on left side changes right high to left low.

Bending head low on right side changes right high to right low.

In both last instances, condyles retain original left side-slip, low on right, high on left.

Bending backward and forward forced bend does not change AS except in degree.

Rotating head left makes atlas appear right high.

Rotating head right makes atlas appear left high.

In both instances, right high is more pronounced. Right condyle is side-slipped TO LEFT in both views. Low on right, high on left.

Head and body down in adjusting position, atlas is high on one side and low on other. Difficult to tell which, because of torsion of all cervical vertebrae and rocking of occiput on atlas and rotation of atlas and occiput on axis.

(For further light on this question of forced positions of head revealing changed facts, see Chapter III, "Definitions, Terms, and Torque Meanings," under "Inter-odontoidean Space".)

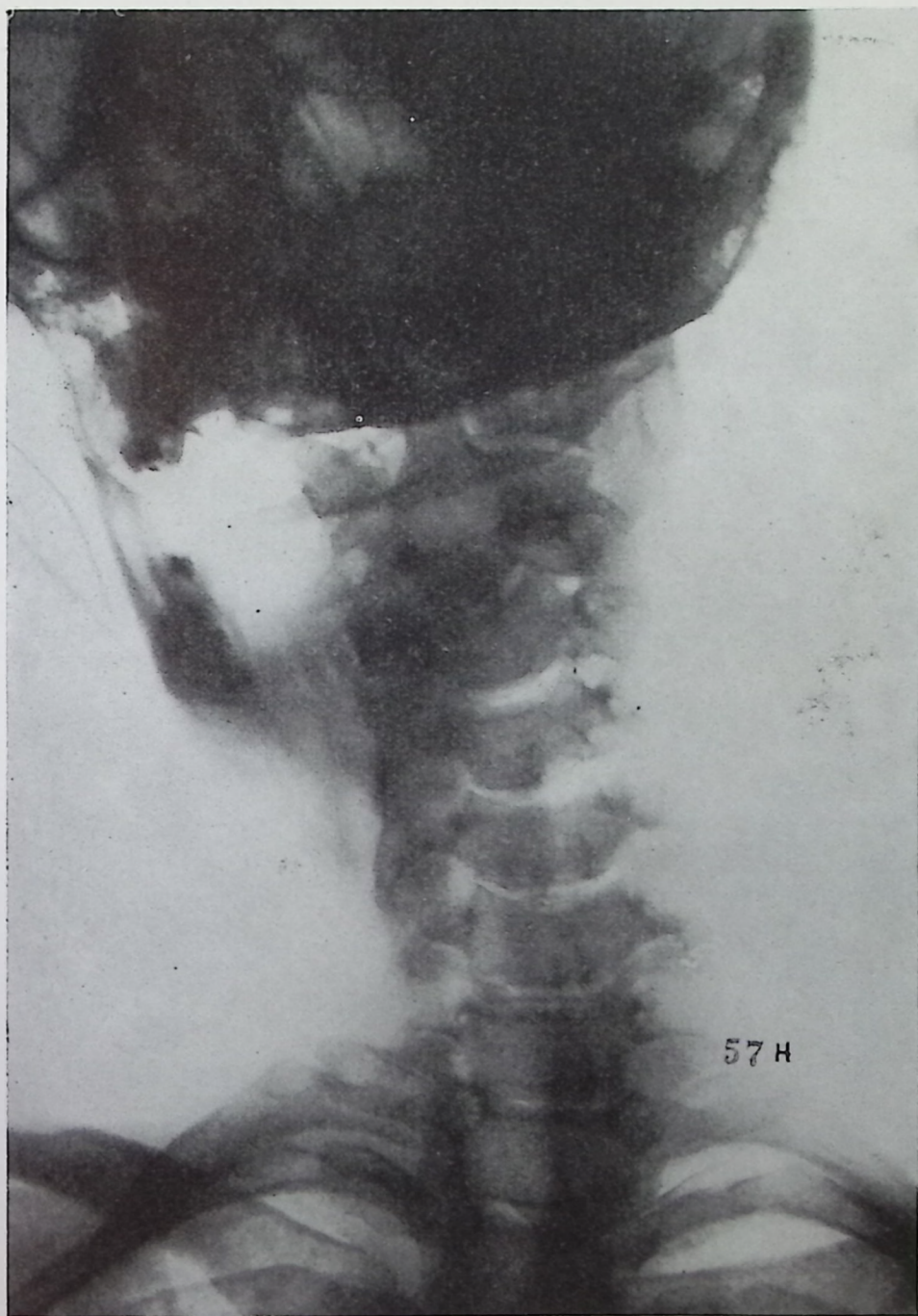


Illustration No. 57

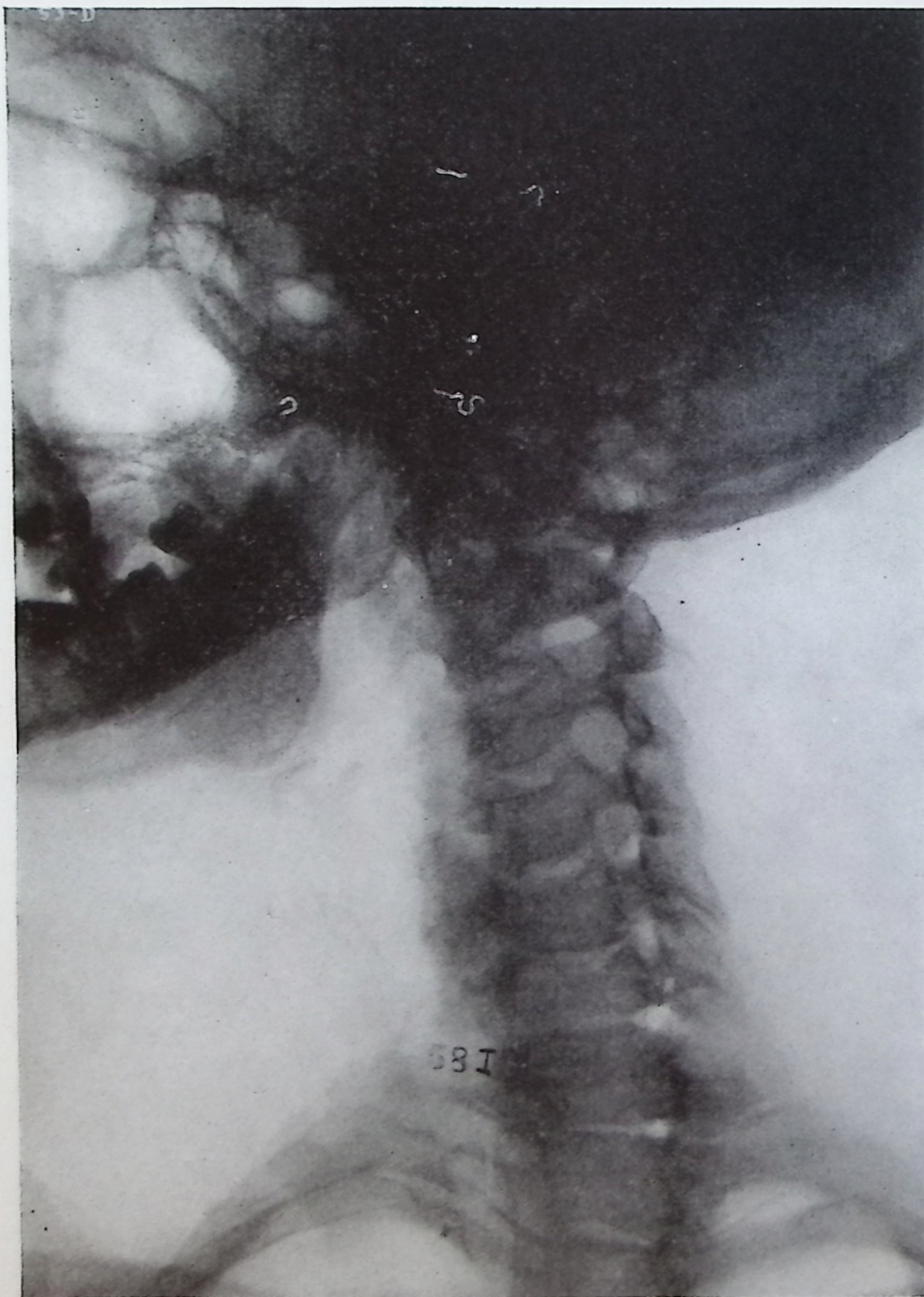


Illustration No. 58

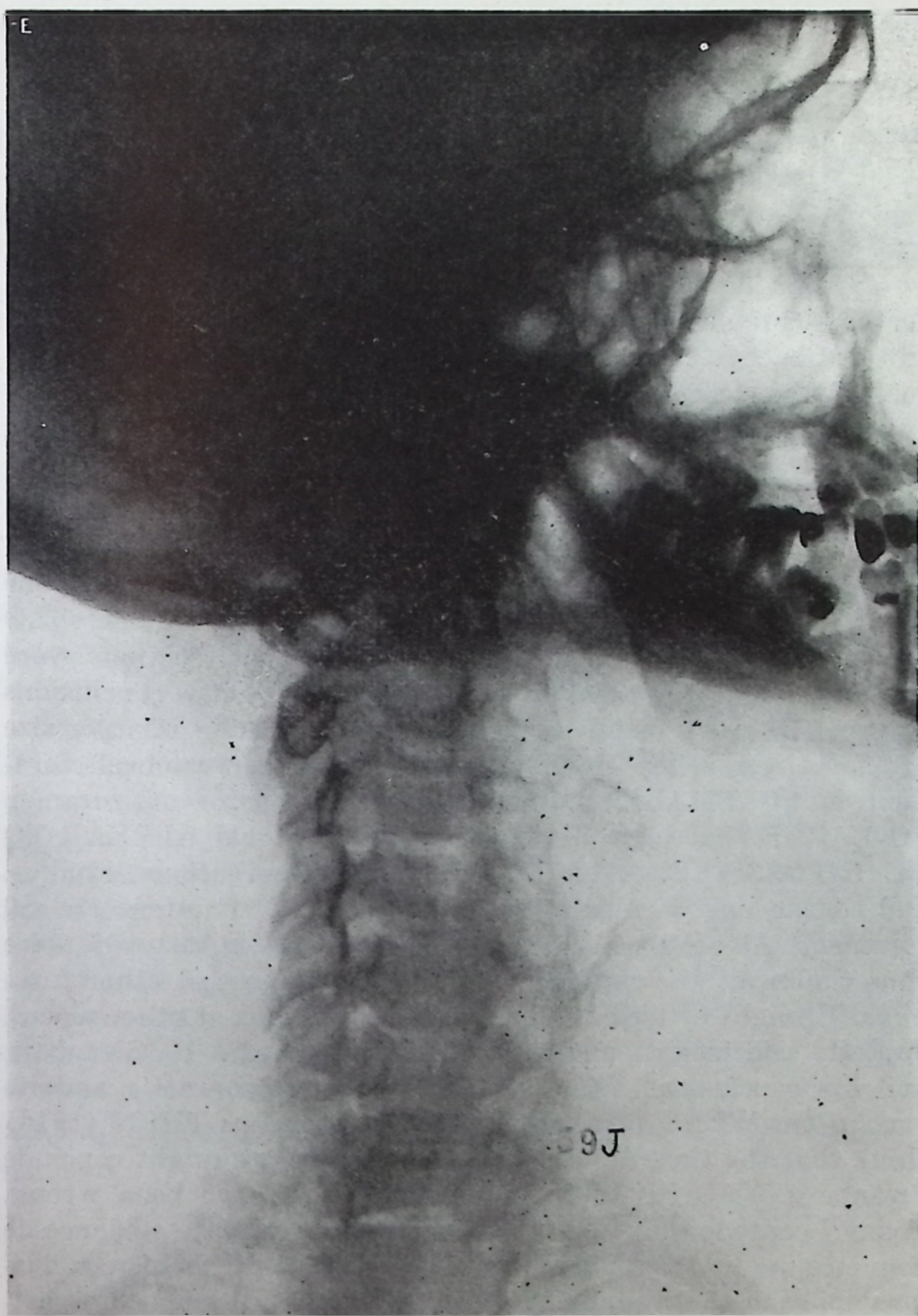


Illustration No. 59

CHAPTER VIII.

SWANBERG DENIES INTERVERTEBRAL SUBLUXATION



WHILE working on the idea contained in this article, it recalled THE INTERVERTEBRAL FORAMEN by Swanberg (1914). The object of that book was to use scientific means to the end of proving that there could be no vertebral subluxation producing pressure upon nerves. Swanberg set forth scientific facts denying the possibility of such; Chiropractic resting ENTIRELY upon the existence of a vertebral subluxation producing pressure upon nerves.

Swanberg took an 8 months female cat, normal size. The right half of the first and second dorsal vertebrae with the vertebral extremity (head and neck) of the right second rib attached was used as the specimen. The specimen was frozen and the bones sawed off so that as small an amount of bone as possible was present around the intervertebral foramen. This specimen was mounted on a block. Microscopic sections were cut, in many layers, enlarged, photographed, and conclusions drawn. In every instance, pictures show that the relative size of nerve emerging from, in, and thru intervertebral foramen is SO SMALL, and the comparative size of foramen SO LARGE that pressure and constriction would APPEAR TO BE IMPOSSIBLE. ALL of Swanberg's observations, studies, and conclusions were based on his work, at ONE intervertebral foramen. All sections, slides, and photographs in his work were thus confined. His summary might not hold true at other foramina. It might be that had he made observations at other places, opposite conclusions might have been reached. IF Swanberg and his conclusions WERE RIGHT, then Chiropractic and its conclusions WERE WRONG. Little did any of us THEN (1914) think that the time (1933) might come when we might conclude Swanberg WAS RIGHT, and that we could have been wrong. Today I concede that further exclusive facts and late evidence do convince me that Swanberg CAN BE right, so far as his conclusions apply to all foramina BELOW CERVICAL. I am still asserting, positively that a vertebral subluxation can and does exist; that it can and does exert pressure; that it can and does interfere

with transmission; but I also assert that Swanberg IS WRONG so far as his conclusions apply ABOVE first dorsal in cervical region.

In 1914, when Swanberg appeared, medical authorities quoted him and made much of his work as it seemingly was a complete scientific refutation of the vertebral pressure Chiropractic principle. I strenuously fought conclusions he reached. Did we not have right to believe he was wrong? Weren't we "adjusting" people below the cervical and getting them well? Wasn't Meric System our guide in use? Weren't we "adjusting" that first and second dorsal vertebra, in adults, and weren't we getting them WELL of troubles we believed had their origination there? In spite of what Swanberg had apparently used scientific means to scientifically prove, we believed he had proved nothing because we alone had the final proof in the restoration of health. Little did we then (1914) know what the future (1933) had in store for us, that might make us agree with him in part. So far as I know, Swanberg is the only book that ever conducted such scientific research to prove or disprove the nerve pressure idea at intervertebral foramen by scientific microscopic tests.

One of the inconsistencies in what is taking place is: you and I have had cases; we have palpated, found "subluxation" according to the meric system; we have "adjusted" them; cases have gotten well. Let us remind ourselves that we were, in those days, "adjusting" every "subluxation" as was, where was, and believed them to be; which was that every palpated deviation WAS a "subluxation"; hence it was rarely that a superior cervical, atlas, or axis did not come in for its share of ADJUSTMENTS at the same time that we "adjusted" merically below. Any conclusion based upon what happened below, could have happened from above and we not know it.

In the INTRODUCTORY NOTE, of Swanberg, Harry E. Santee says:

"Mr. Swanberg shows by actual sections the exact relations of the first dorsal nerve at the intervertebral foramen. A study of his work will help to determine whether compression of the nerves at this point is likely to occur; and whether, therefore, there is substantial ground for the doc-

trine that such compression is the immediate cause of all or of a considerable number of pathologic conditions."

The PREFACE contains this statement:

"During the past quarter of a century a great deal of attention has been directed to the spinal column from a therapeutical standpoint. MANY SYSTEMS HAVE ARISEN CLAIMING THAT THE GREAT MAJORITY OF DISEASES HAVE THEIR ORIGIN FROM VARIOUS SPINAL ABNORMALITIES, WHICH RESULT IN PRODUCING PRESSURE, OR OTHER PHENOMENA, TO THE NERVES IN THE INTERVERTEBRAL FORAMINA. It is not the purpose of this book to discuss any of the pathologic changes which take place to the nerves or the intervertebral foramina, but to present a clear and concise description of the normal histologic structure of this part, with special reference to the relations of the nervous structures. Once the normal structure is mastered, the reader will then be in a better position to judge for himself the effects of pathologic changes to these parts, and can formulate his own opinion about NERVE PRESSURE, IMPINGEMENT, irritation, etc., as a cause of disease."

The SUMMARY, at conclusion of book, contains:

"Another interesting fact IS THE SIZE OF THE SPINAL NERVE AS COMPARED WITH THE INTERVERTEBRAL FORAMEN. This is very well shown in Plate 3, where the foramen IS ABOUT THREE TIMES THE SIZE OF THE NERVE. The intervertebral disc between the first and second dorsal vertebrae averages approximately 1 mm. in thickness. If the disc should shrink, the foramen would be reduced in size, and this reduction would be principally in a supero-inferior diameter; the pedicles of the two vertebrae tending to approach one another. If it should shrink away entirely, the foramen would be reduced from its normal 4 mm. supero-inferior diameter to about 3 mm. However, EVEN THEN IT WOULD BE IMPOSSIBLE FOR THE NERVE TO BE PINCHED BY BONE.

"Should the articular cartilages on the articular processes undergo thinning, the foramen would be actually increased

in size. This increase would be principally in an antero-posterior diameter, the distance between the superior articular process of the second dorsal, and the body of the first dorsal being increased on account of the superior articular process passing posteriorly. The thickness of each articular cartilage on these processes is approximately $\frac{1}{4}$ of a mm. If they should both undergo complete atrophy the foramen would be actually increased about $\frac{1}{2}$ a mm. in its antero-posterior diameter.

"From dissection-room observations, I believe I am justified in stating that if any changes occur in the size of the intervertebral discs or the articular cartilages, they have a marked tendency to become thinner rather than thicker. Should both the disc and the articular cartilages undergo thinning at the same time, the foramen would not, in all probability be decreased as much in size as when the disc itself is thinned. I have seen many ankylosed specimens where the intervertebral foramina have been greatly reduced in size, but in every instance THERE SEEMED ENOUGH ROOM FOR THE NERVE TO PASS FREE FROM ANY BONY PRESSURE. Possibly in some such cases, the nerve may be subject to actual bony pressure, but from my observations, this occurrence is extremely rare.

(Illustrations 10 to 16 portray specimens which provide substance for above statement. Illustration 17 clearly shows reverse, how a vertebral misplacement will, can, and does occlude a spinal neural canal.)

(This subject is more fully discussed towards the close of this chapter. We suggest you bear this reference in mind and apply it to this thot.)

"Remember, the nervous structures in the spinal canal and intervertebral foramen are embedded in fat. This tissue in the living subject is in a semi-fluid condition. Thus we see that the nervous structures are embedded in a semi-fluid substance, one of the body's best protective agencies. The nerves being composed of such a highly specialized tissue, and therefore so vital, nature seems to use every possible precaution to protect them from bony pressure. This is the reason, no doubt, that the intervertebral foramina, in both animal and man, are so much larger than the nerves themselves."

HIO DENIES AND AFFIRMS SWANBERG

The HIO now presents facts, proof and evidence that Swanberg WAS right, insofar as vertebrae, including the first and second dorsal and from there up and down so far as all intervertebral foramina are concerned. I am more convinced now than ever, that Swanberg could not be right so far as occiput, atlas and axis in neural canal and spinal cord pressures are concerned.

From various sources, prejudicial and scientific, there has been opposition to the fundamental principles of Chiropractic, viz., intervertebral occlusion of a foramen could, would, and did produce pressure upon nerves. There was little opposition to the sequence that an occlusion with pressure did interfere with transmission of mental impulse supply, on the ground that if the occlusion could not occur, then pressure was impossible; and with no pressure there could be no interference to transmission.

The basic opposition was directed to the impossibility of occlusion sufficient to produce pressure, contending that nerve fibres or nerve trunk is so small and foramen so large, by comparison to each other, and range of movement of two contiguous appositional vertebrae so limited that it would be impossible for two vertebrae to compress themselves together sufficient to decrease the size of the intervertebral canalicular foramen sufficient to produce pressure upon any fibres passing through, between. Therefore all Chiropractic either lives or dies for anatomical proofs to sustain its fundamental.

Swanberg (as elsewhere enlarged upon in this article) froze an anatomical section at first dorsal. He showed that the nerve WAS small and the intervertebral foramen WAS large, and that even though two contiguous vertebrae WERE entirely compressed, and even if there was NO intervertebral cartilaginous disc between, it still could not produce pressure upon nerves passing between same. In that portion of this article we have agreed in part, and disagreed in another part.

It is anatomically true that, broadly speaking, the spinal canal gradually DECREASES IN SIZE from above downward; from the atlas neural canal to the fifth lumbar neural canal. It is further anatomically true that, broadly speaking, the intervertebral

foramina increase in size from above downward; from the third cervical intervertebral foramina to those of the fifth lumbar intervertebral foramina. It is further anatomically true that the QUANTITY OF NERVE FIBRES DECREASES in number as they divide from above downward as they pass off from and decrease their number from above downward. It is further anatomically true that THE GREATEST MOTION IS AT THE TOP AND THIS MOTION GRADUALLY LIMITS ITSELF, by comparison, getting less, in rotation, extension, and flexion, as we go from above downward. The more superior the vertebra, the greater its motion; the more inferior the vertebra, the less motion it possesses, by comparison. The greatest motion is obviously in superior cervical region. The next greatest is in lumbar region, the dorsal having least.

Upon this series of anatomical facts we have:

1. The lower the vertebra, THE LESS MOTION.
2. The lower the vertebra, THE LARGER THE FORAMINA.
3. The lower the vertebra, the larger the foramina, THE FEWER FIBRES pass through it; therefore the inevitable conclusion that we are less liable to have interference from vertebral misalignment, with less occlusion; less pressure; less interference to transmission.

The opposite of the first premise is also true. The spinal cord INCREASES ITS SIZE from below upward; the intervertebral foramina DECREASE IN SIZE from below upward; THE QUANTITY OF FIBRES INCREASES IN NUMBER FROM BELOW UPWARD as they assemble and gather into and help form the spinal cord on their way either into or from the brain; both afferent and efferent carrying directions. It is further a fact that vertebrae INCREASE THEIR MOTION either in rotation, extension, or flexion, as they exist from below upward, including the rocking backward and forward of the occiput upon the atlas; occiput and atlas rotation upon and within the axis, etc.

Upon this same series of anatomical facts, here is what we also reach:

1. The more superior the vertebra, THE MORE MOTION.
2. The more superior the vertebra, THE SMALLER THE FORAMINA.

3. The more superior the vertebra, the smaller the foramina, **THE MORE FIBRES** passing through them; therefore the inevitable conclusion that we are more liable to have a possible subluxation, with more occlusion; more pressure; more interference to transmission.

(See Illustration No. 140 and descriptive text that goes with it which emphasizes the third point, in NCM readings.)

Facts justify the meritorious assertion that a subluxation cannot occur where there is room, even under compression, for nerves to emit without interference to their carrying transmission capacity. The evidence shows that up in and around the magnum foramen, between magnum foramen and atlas, inside the bony ring of atlas as interfered with by odontoid of axis, between inferior margin of atlas and superior margin of axis; where motion is greatest; where foramina are smallest; where the greatest quantity of fibers exists, mechanically the greatest possibilities exist for pressure, compression, constriction, that there is every reason to maintain that here is **ONE PLACE** where no anatomical argument could disprove or dispel the assertions we herein lay down for and in behalf of the substantiation of the fundamental Chiropractic principle.

Swanberg sets forth:

1. Individual nerve passing thru a foramen is small
2. Intervertebral foramen is large
3. Nerve is small and foramen is large
4. Therefore pressure is impossible. Swanberg's observations were confined to one place, viz., between 1st and 2nd dorsal vertebrae. His conclusions of similar deductions at other foramina are as true of them as of one cited.

Swanberg could also have said:

5. Because of interlocking of vertebrae, degree of free play motion is limited to and between locks.
6. Even if motion were considerable, small size of nerve and large size of foramen prohibits constriction pressure.

The opposite of all this is true as we ascend in neural canal.

1. Spinal cord increases in size
2. Neural canal, while large, decreases in ratio
3. Spinal cord is large and neural canal is small
4. Three main and general directions of motion between oc-

ciput, atlas and axis are not subject to any osseous lock; therefore, in this region vertebral subluxation is a reality.

5. Therefore pressure is inevitable. Spinal cord is an accumulation and assembling of all efferent and afferent fibers that go to or come from all the body. As they gather, they more nearly, in ratio, fill neural canal. Amount of free play is decreased. Amount of motion in extension and counter-extension; flexion and counter-flexion and rotation is materially increased as we reach atlas, axis, and occiput. These facts, plus absence of osseous locking of vertebral motion, make constricted pressure a reality and of paramount and vital importance.

The actual location of pressure is vital to know. I seriously doubt if there can be ANY pressure between vertebrae in the intervertebral foramina. There may be merit in the general statement made by anatomists and neurologists that the space is SO large and the nerve SO small that it IS impossible to have pressure there. We have at least progressed far enough in our research work to be completely satisfied that there are no pressures at intervertebral foramina BELOW axis in any of the balance of the cervical, dorsal, or lumbar vertebrae. Why should there be any between the three superior cervical vertebrae? May it not actually BE true that pressures are confined to the intervertebral spaces enclosing, surrounding, and constricting THE SPINAL CANAL? The actual displacement possible, as we go inferior, becomes micrometrically in its minuteness, getting less the farther down we go, even tho vertebrae get larger and number of fibres diminished. The actual displacement possible, as we go superior becomes greater in magnitude, getting larger the farther up we go, even tho vertebrae get smaller and number of fibres multiplied.

The vital spots to keep in mind are:

- (a) Between inferior surface of magnum foramen and superior surface of superior ring of atlas.
- (b) Mal-position of odontoid process as it squeezes itself into spinal canal because of distortions existing between atlas and axis.
- (c) Between inferior surface of atlas and superior surface of axis.

It is these intermediary spaces BETWEEN inferior AND

superior surfaces that are VITALLY affected IN MAGNITUDE mechanically that gives THE specific pressures that become of such importance in THIS PARTICULAR REGION.

When observing these kinks, twists, wrenches, or torques, see what is ACTUALLY the direct effect of the intermediary spaces mentioned, as well as the size, shape, of spinal canal because of odontoid process.

THE MYSTERY OF AGES REVEALED

Notwithstanding the HIO PRINCIPLE HAD NOW BEEN ESTABLISHED IN PRACTICE in clinical cases, satisfactory to all who used the system with accuracy and did not under-rate or over-rate elements involved, there still existed the unknown element of WHY IS THE MAJOR SPECIFIC LOCATED AT THIS PARTICULAR CERVICAL PLACE AND IS NOT FOUND AT ANY OTHER IN THE SPINAL COLUMN? Now comes the SECOND half of No. 3 in answer to that phase of our problem.

Let us interpolate for the moment. I was the first Chiropractor to introduce the X-ray into our work. It is not now apropos that we reiterate the first objective was to prove the existence of a vertebral subluxation; second to verify our palpations or to correct them; third to seek for and locate "subluxations," etc.- Between the time of its introduction and the time before the profession awakened to its indispensability, I had taken many thousands of spinographs, studied them in conjunction with case research work. There came a time when I stepped out of the active exposure of plates, developing and interpreting them. We then built up one of the most complete and largest spinograph laboratories in the world where assistants continued research work under my direct contact and direction. I have been a constant research student, seeking further light in newer and better explanations of solutions of unknown problems hidden in our new science.

There were too many ifs, ands and buts which permitted too many chiropractors to offer too many contradictory elements, from which too many chiropractors could and did develop too many opposing conclusions. There were too few established, definite, specific facts upon which chiropractors could reliably and substantially agree.

Notwithstanding I have been in direct touch with our spino-

graphic laboratories and work is being conducted under my guidance, I have NEVER been satisfied that we had reached any accurate, satisfactory, or simplified form of correctly reading films consistent with facts we should have. FOR THE FIRST TIME, I CAN NOW SAY WE HAVE REACHED THAT SOLUTION WHICH WE HAVE BEEN SEEKING 23 YEARS AFTER HAVING STUDIED HUNDREDS OF THOUSANDS OF FILMS.

"How is it, Doctor, that I have taken pictures of my cases BEFORE adjustment; adjusted them for a long period, spinographed again and, to all appearances, the vertebrae seem to be in the same position as when I first spinographed?" "How is it, Doctor, that my cases come sick, go home well, yet I note no difference in the position of any vertebra I believed showed subluxation?" There have been occasional and accidental, before and after cases, where vertebrae DID show a difference in position. Why did some show a change, while the majority did not? These and more questions have been answered by showing that when a SUBLUXATION, in fact, HAD BEEN adjusted, the subluxation DID disappear. When they were misalignments that we were "adjusting," no amount of "adjusting" ever could, did, or would change them. We were trying to read misalignments AS subluxations, and did not know the difference.

WHAT WILL THE SPINOGRAPH NOW SHOW?

(Read also "Care in Establishing Facts," under Chapter VIII. Check Illustrations 50-55 with descriptive text.)

In reading spinographs, several means are at our disposal:

1. Caliper measurements between spinous and transverse processes, etc.
2. Plane lines.
3. A large magnifying glass.

Of the three, I prefer the latter two. Calipers give only a comparative measurement position of one point with another like point between two given points, and tend to limit observation to points between pointers of a pair of calipers. To use calipers, person must be close to and almost on top of spinograph view boxes. Plane lines give a true general picture of the relative all-vertebral comparative positions between THREE vertebrae. Magnifying glass, if large enough, tends to introduce the

third dimension of depth into picture. I do not say it does, but that it TENDS to do so. I use glass $4\frac{1}{2}$ inches in diameter and one six inches would be better. It is large enough to take in ALL the area of an occiput, atlas, and axis.

(See Illustrations 143-144 which illustrate large magnifying method of interpreting spinographs.)

The Spinograph picture shows soft and hard tissue detail which can be read and interpreted to prove positions of contiguous organs. It is used by the Chiropractor to produce bone shadows to study comparative positions of relative vertebrae, to ascertain the correct and incorrect positions of vertebral subluxations and misalignments.

One of the common remarks amongst our profession is: "Why is it, when I find a 'subluxation' and adjust it for months, and then take another Spinograph, I do not see any difference in position of vertebrae which compose that 'subluxation'?" That this is true is generally believed. Other cases show a "before and after" picture which proves a corrected position of a vertebra which was analyzed as SUBLUXATED. Many of us have had pictures which prove both contentions.

Many cases come here sick, take "adjustments", get well. We have taken spinographic pictures before and after. And very little, if any, change can be noted in position. We have had other cases come sick, taken pictures, given ADJUSTMENTS; they get well. We take another picture and there is a marked change in position of vertebrae.

What, then, IS this difference? Which of two types should EVERY case be?

If a subluxation IS a SUBLUXATION, then it is out of normal relationship. If an adjustment IS an ADJUSTMENT, then it must be restored to normal relationship. Some cases go to a Chiropractor—and don't get well. The same case may go to another Chiropractor—and get well. Some cases get well by accident; others by intention. Some get well in spite of the Chiropractor; others because of him. Some get well with NCM; others without. What IS that fundamental? Can we decipher it, work for it, apply it knowingly? That some cases get well, with the "subluxation" existing; and other cases get well with the SUBLUXATION unquestionably gone, proves that slightest re-

leasure of pressure can accidentally get a case well, with our having no visual knowledge of the correction of the vertebra. I think it safe to say that when an ADJUSTMENT ("the adjustment with that extra something") HAS been given, and the vertebra HAS been restored from the abnormal to the normal position, as evidenced by spinographs of before and after; then the case IS well, given time, and all else being equal. I think it safe to say, when an "adjustment" has been given and vertebra does not change from abnormal to normal position, as evidenced by spinographs of before and after, that the case WOULD be well; would GET well; or would REMAIN well, notwithstanding he apparently does not seem so now. I think whatever results he SEEMINGLY has secured would be temporary. All of us have had cases that have done that very thing.

What, then, IS this difference? In a case where an ADJUSTMENT ("the adjustment with that extra something") has been given on a SUBLUXATION revealed by Spinograph, at a place located by NCM, which has proved to be a major, because of check-outs; AND THOSE READINGS REMAIN GONE FOR GREAT INTERVALS of time, say from 5 days to 3 or 4 weeks at a stretch — in time THAT CHANGE WILL PROVE TO BE AN ADJUSTMENT, by Spinograph in correction of its position. But, in a case where an "adjustment" is given DAILY on a "subluxation" revealed by spinograph at a place located by NCM, which has proved to be a major because of check-outs; and those readings KEEP COMING BACK DAY AFTER DAY—necessitating a repeated daily "adjustment"—that change will NOT prove to be a permanent correction by Spinograph in position assumed by that vertebra.

Where an ADJUSTMENT ("the adjustment with that extra something") is given AND IT REMAINS, then the vertebra not only assumes its normal position from its abnormal, but tends to stay there. Where an "adjustment" is given, AND IT RE-APPEARS DAILY, then the vertebra has been merely JARRED FROM WHERE IT WAS, TO SOMEWHERE BETWEEN WHERE IT WAS to where it should be; but readily works back to where it was, daily, and will not tend to stay there. There is NOW a distinction to be made, even with visual spinographic plates of vertebral "subluxations" between ADJUSTMENTS

that stay put and those that merely, daily, jar one from one position to another, only to work back to where it does not belong.

The original question was, "What is the difference in what happened between a SUBLUXATION that is ADJUSTED and shows a PERMANENT changed position by the Spinograph; and that case where you "adjust" for a long period, case seemingly gets well and shows no difference in position of vertebra by Spinograph?" The difference is: in one instance you gave AN ADJUSTMENT ("the adjustment with that extra something") and in other you gave merely a SERIES OF JARRINGS which TEMPORARILY moved vertebra sufficiently to produce a TEMPORARY improvement which is sufficiently marked to make case believe she or he is well.

There are several "systems" of how to adjust, peddled about the country today, based upon the idea of a series of tappings, jarrings, or a prolonged pressure upon vertebrae, notably the three times rappings upon each vertebra, up one side and down the other. The percussion hammer method is directly in point. It can be made to stimulate or inhibit heart action by vibrational tappings on vertebrae. The worst of all these methods is that they do get immediate altho temporary changes in remote function which they construe to be a health return. It does not, because it cannot, be permanent.

If you give an ADJUSTMENT ("the adjustment with that extra something") on January 1st and not find it necessary to give another before February 1st (and this interval is cited to act as an example only), because of no recurrence of the mal-position of that vertebra during the interim, you have given an ADJUSTMENT ("the adjustment with that extra something"). If you give an "adjustment" on January 1st and find it necessary to give another "adjustment" DAILY until February 1st, (and this time is cited to act as an example only) because of a daily recurrence of the mal-position of that vertebra during the daily intervals, I doubt very much if you have done anything but vibrated or jarred the vertebra. As well use a vibrator or percussion hammer and gain the same end.

And at this juncture, before some misconstrue my position, I

do not mean that you must use a terrific wallop to give an ADJUSTMENT in contrast to a series of tappings to give an "adjustment" which is not one. One of these would defeat the end as much as the other. The value of an ADJUSTMENT is not to be measured by violence of quantity of force used, or by driving force that almost forces it thru the body. Light application, directed with speed, securing that snappy recoil from Innate is what will accomplish AN ADJUSTMENT ("the adjustment with that extra something") whereas nothing else can.

Illustration No. 60.

Pen and ink schematic drawing to illustrate right high side-slip Atlas subluxation.

Head is high on right. Atlas has side-slipped TO right. Occiput appears low on right.

Right lateral of atlas is closer to occiput, on right.

Left lateral of atlas is farther apart from occiput, on left.

Compare with actual spinographic illustrations in Chapter 37.

Illustration No. 61.

Pen and ink schematic sketch drawing to illustrate left high side-slip atlas subluxation.

Head is high on left. Atlas has side-slipped TO left. Occiput appears low on left.

Left lateral of atlas is closer to occiput, on left.

Right lateral of atlas is farther apart from occiput, on right.

Compare with actual spinographic illustrations in Chapter 38.

Illustration No. 62.

Pen and ink schematic sketch drawing to illustrate right low side-slip atlas subluxation.

Head is low on right. Atlas has side-slipped TO right. Occiput appears low on right.

Right lateral of atlas is closer to occiput, on right.

Left lateral of atlas is farther apart from occiput, on left.

Compare with actual spinographic illustrations in Chapter 39.

Illustration No. 63.

Pen and ink schematic sketch drawing to illustrate left low side-slip atlas subluxation.

Head is low, on left. Atlas has side-slipped TO left. Occiput appears low on left.

Left lateral of atlas is closer to occiput, on left.

Right lateral of atlas is farther apart from occiput, on right.

Compare with actual spinographic illustrations in Chapter 40.

Illustration No. 64.

Pen and ink schematic sketch drawing to illustrate the effect of a side-slip atlas subluxation occluding the foramen inferior of magnum foramen and superior of atlas neural canal. It is observable that it does side-slip and side-presses upon the spinal cord as it passes thru from one to the other.

Illustration No. 65.

A schematic drawing looking downward (inferior) thru the atlas and axis, from above. Shows a subluxation of axis posterior and inferior, with odontoid back into neural canal. A companion drawing to the natural photo of Illustration No. 25.

In presenting the next set of views of subluxations, we shall offer two ways of expressing the idea: (a) A schematic pen and ink drawing of each type; (b) an A-P and Lateral set of spinographs following the exact lines as the drawing portrayed; thus linking the schematic with the actual.

Illustration No. 66.

Schematic pen and ink drawing. A-P only, of an Axis PLI true vertebral subluxation.

Head is low on right

Atlas is low on right

Axis is low on right

Axis spinous process is to left of median line.

Illustration No. 67. (Companion to Illustration No. 68)

A-P spinograph of an Axis PLI true vertebral subluxation.

Head is low on right

Atlas is low on right

Axis is low on right

Axis spinous process is to left of median line.

Illustration No. 68. (Companion to Illustration No. 67)

Lateral Spinograph of an Axis PLI true vertebral subluxation.

Spinous process of axis is inferior

Centra between axis and 3rd cervical are separated.

Odontoid process is posterior and inferior into neural canal.

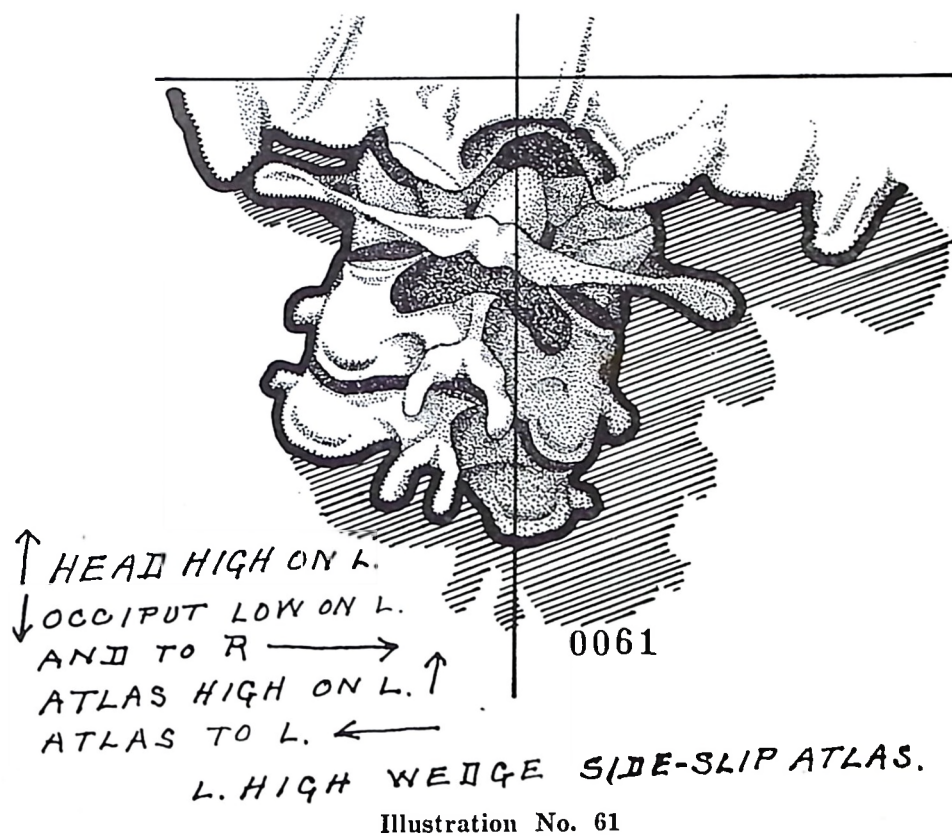
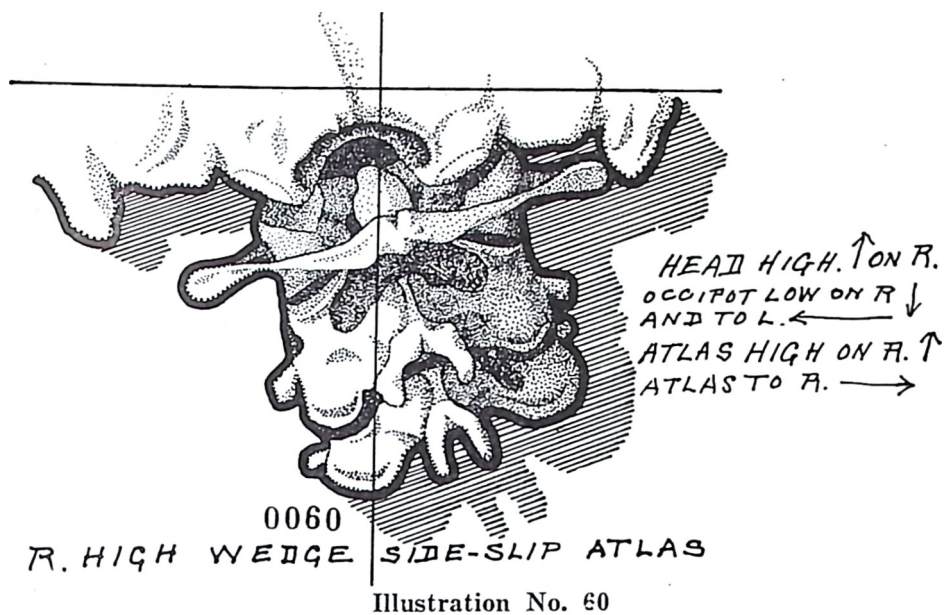


Illustration No. 69.

Schematic pen and ink drawing, A-P only, of an Axis PRI true vertebral subluxation.

Head is low on left

Atlas is low on left

Axis is low on left

Axis spinous process is right of median line.

Illustration No. 70. (Companion to Illustration No. 69)

A-P spinograph of an Axis PRI true vertebral subluxation.

Head is low on left

Atlas is low on left

Axis is low on left

Axis spinous process is right of median line.

Illustration No. 71. (Companion to Illustration No. 70)

Lateral spinograph of an axis PRI true vertebral subluxation.

Spinous process of axis is inferior.

Centra are not separated to any great extent, on anterior inferior of axis.

3rd cervical centrum appears anterior of axis.

Odontoid process of axis is posterior and inferior into neural canal.

Illustration No. 72.

Schematic pen and ink drawing A-P only, of an Axis PLI false vertebral subluxation.

Head is low on right

Atlas is low on right

Axis is low on right

Axis spinous process is right of median line.

Illustration No. 73. (Companion to Illustration No. 74)

A-P spinograph of an Axis PLI false vertebral subluxation.

Head is low on right

Atlas is low on right

Axis is low on right

Axis spinous process is right of median line.

Illustration No. 74. (Companion to Illustration No. 73)

Lateral spinograph of an Axis PLI false vertebral subluxation.

Spinous process of axis is very much inferior on posterior.

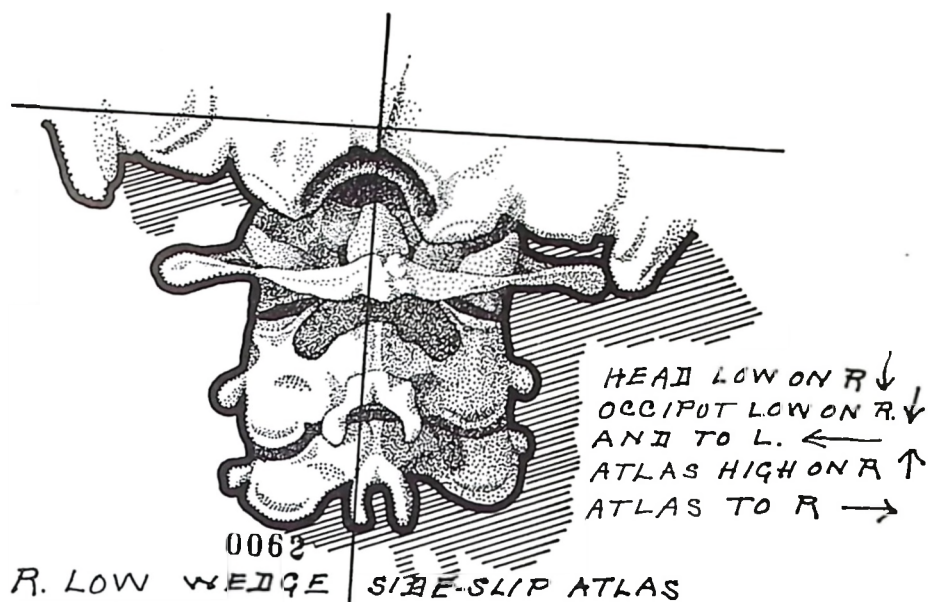


Illustration No. 62

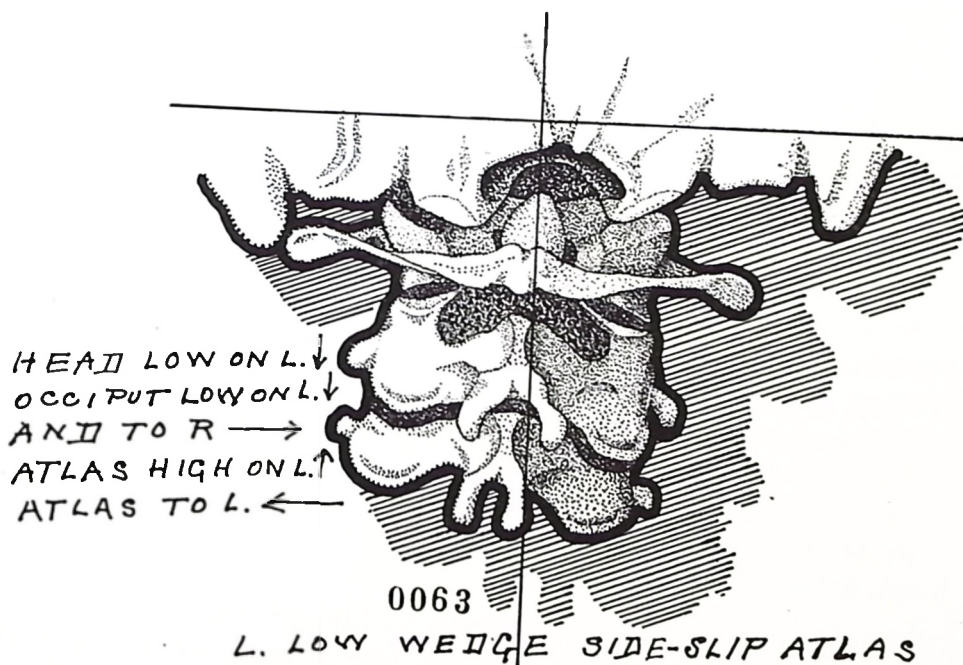


Illustration No. 63

Centra between axis and 3rd; between 3rd and 4th cervical vertebrae are separated abnormally.

Axis being so far inferior, draws atlas backward with compensatory head low on rear.

Odontoid process of axis is posterior and inferior into neural canal.

Illustration No. 75.

Schematic pen and ink drawing, A-P only, of an axis PRI false vertebral subluxation.

Head is low on left

Atlas is low on left

Axis is low on left

Axis spinous process is left of median line.

Illustration No. 76.

A-P spinograph of an axis PRI false vertebral subluxation.

Head is low on left

Atlas and axis low on left

Axis spinous process is left of median line.

Illustration No. 77. (Companion to Illustration No. 76)

Lateral spinograph of an Axis PRI false vertebral subluxation.

Spinous process of axis is inferior on posterior.

Centra between all cervical vertebrae, below, are separated abnormally.

Odontoid process of axis is posterior and inferior into neural canal.

Illustration No. 78.

Schematic pen and ink drawing, A-P only, of an Axis PI false vertebral subluxation.

Head can be low on left or right

Atlas can be low on left or right

Axis can be low on left or right.

Spinous process is in median line; neither to left nor right.

Spinous process, however, would be adjusted from side which head, atlas, or axis is low on.

Illustration No. 79. (Companion to Illustration No. 78)

Schematic pen and ink drawing, lateral only, of an Axis PI False.

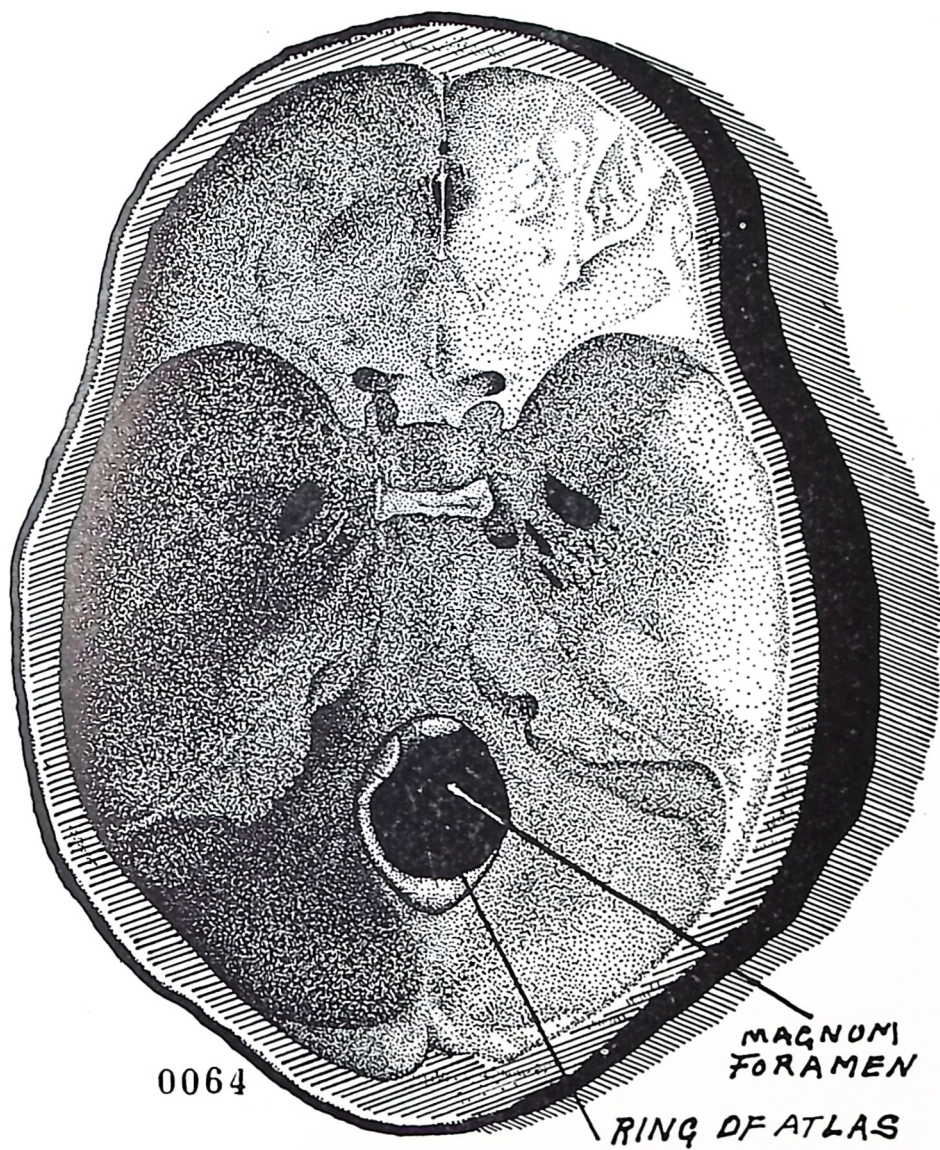


Illustration No. 64

Illustration No. 80. (Companion to Illustration No. 81)

A-P spinograph of an Axis PI false vertebral subluxation.

In this case head is low on right

Atlas is low on right

Axis is low on right

Spinous process is in median line.

Listing in this case would be "False PI axis"; adjust from L.

Illustration No. 81. (Companion to Illustration No. 80)

Lateral spinograph of an axis PI false vertebral subluxation.

Spinous process of axis is very much inferior on posterior, crowding 3rd.

Centra between axis and 3rd cervical very much exaggerated.

Odontoid process of axis very much posterior and inferior into neural canal.

Illustration No. 82.

Schematic pen and ink drawing, lateral only, of an atlas AI (anterior and inferior) vertebral subluxation.

Anterior arch of atlas is anterior of normal position.

Anterior arch of atlas is inferior on its articulation with odontoid.

Whether the AI atlas is S on left or I on right depends upon what the A-P view reveals.

Illustration No. 83.

Lateral spinograph of an atlas AIR vertebral subluxation.

Anterior arch of atlas is anterior of normal position.

Anterior arch is inferior, the head, atlas, and axis comparative positions considered.

Whether the AI is L (left) or R (right) depends upon what the companion A-P view reveals.

Illustration No. 84. (Companion to Illustration No. 83)

A-P spinograph of an atlas AIR vertebral subluxation.

The head, atlas, and axis are low on right.

On lateral view, atlas AI, coupled with A-P view, makes it low on right; therefore an AIR atlas.

Illustration No. 85. (Companion to Illustration No. 86)

Illustration No. 82, pen and ink drawing, also is typical of this vertebral subluxation.

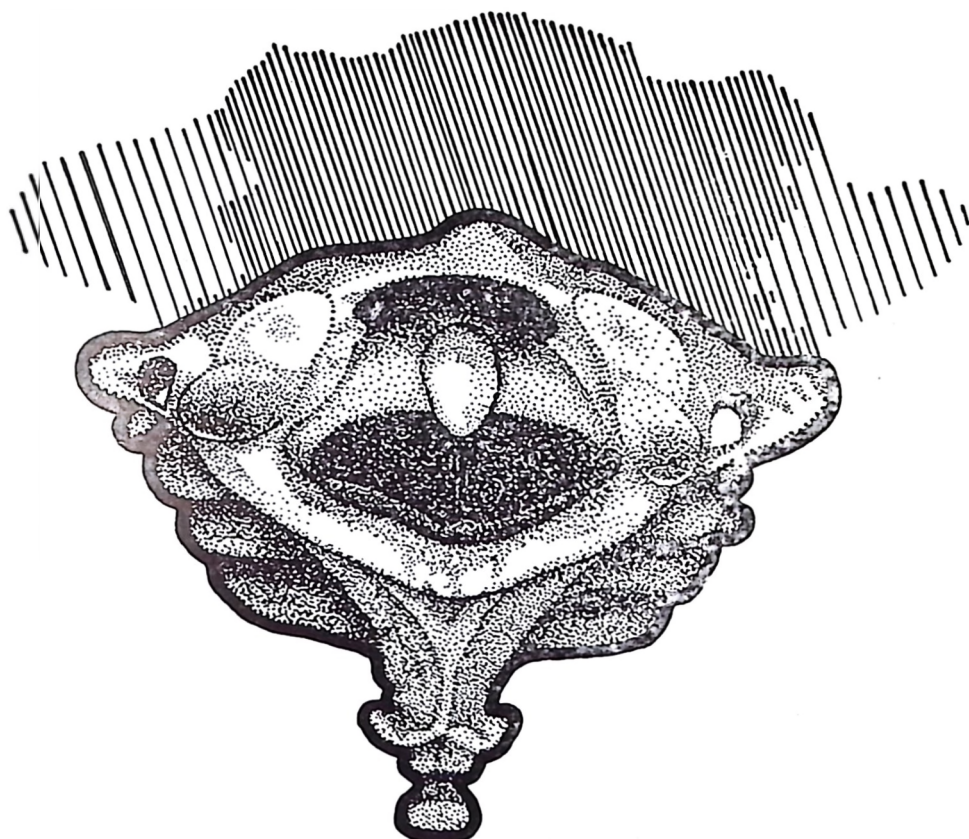


Illustration No. 65

Lateral spinograph of an atlas AIL vertebral subluxation.

Anterior arch of atlas is anterior of normal relationship with axis.

Anterior arch is inferior, the head, atlas, and axis comparative positions considered.

Whether the AI is L (left) or R (right) depends upon what the companion A-P view reveals.

Illustration No 86. (Companion to Illustration No. 85)

A-P spinograph of an atlas AIL vertebral subluxation.

The head, atlas, and axis are low on left.

On lateral view, atlas AIL coupled with A-P view, makes it low on left; therefore an AIL atlas.

Illustration No. 87.

Schematic pen and ink drawing, lateral only, of an atlas AS (anterior and superior) vertebral subluxation.

The anterior arch of atlas is anterior of normal position.

The anterior arch of atlas is superior on its articulation with anterior of odontoid.

Whether the AS atlas is L (left) or R (right) depends upon what the lateral view reveals.

Illustration No. 88. (Companion to Illustration No. 89)

Illustration No. 87, pen and ink drawing, also is typical of this vertebral subluxation.

Lateral spinograph of an atlas ASR vertebral subluxation.

Anterior arch of atlas is anterior of normal relationship with axis.

Anterior arch of atlas is superior; head, atlas, and axis comparative relationships considered.

Whether the AS is L (left) or R (right) depends upon what the companion A-P view reveals.

Illustration No. 89. (Companion to Illustration No. 88)

A-P spinograph of an atlas ASR vertebral subluxation.

The head, atlas, and axis are superior on right.

On lateral view, atlas AS, coupled with A-P view where atlas is superior on right; therefore an ASR atlas.

Illustration No. 90. (Companion to Illustration No. 91)

Lateral spinograph of an atlas ASL vertebral subluxation.

Anterior arch of atlas is anterior of normal relationship with axis.

Anterior arch is superior; head, atlas, and axis comparative positions considered.

Whether the AS is L (left) or R (right) depends upon what the companion A-P view reveals.

Illustration No. 91. (Companion to Illustration No. 90)

A-P spinograph of an atlas ASL vertebral subluxation.

Head, atlas, and axis are superior on left.

On lateral view, atlas AS, coupled with A-P view where atlas is superior on left; therefore an ASL atlas.

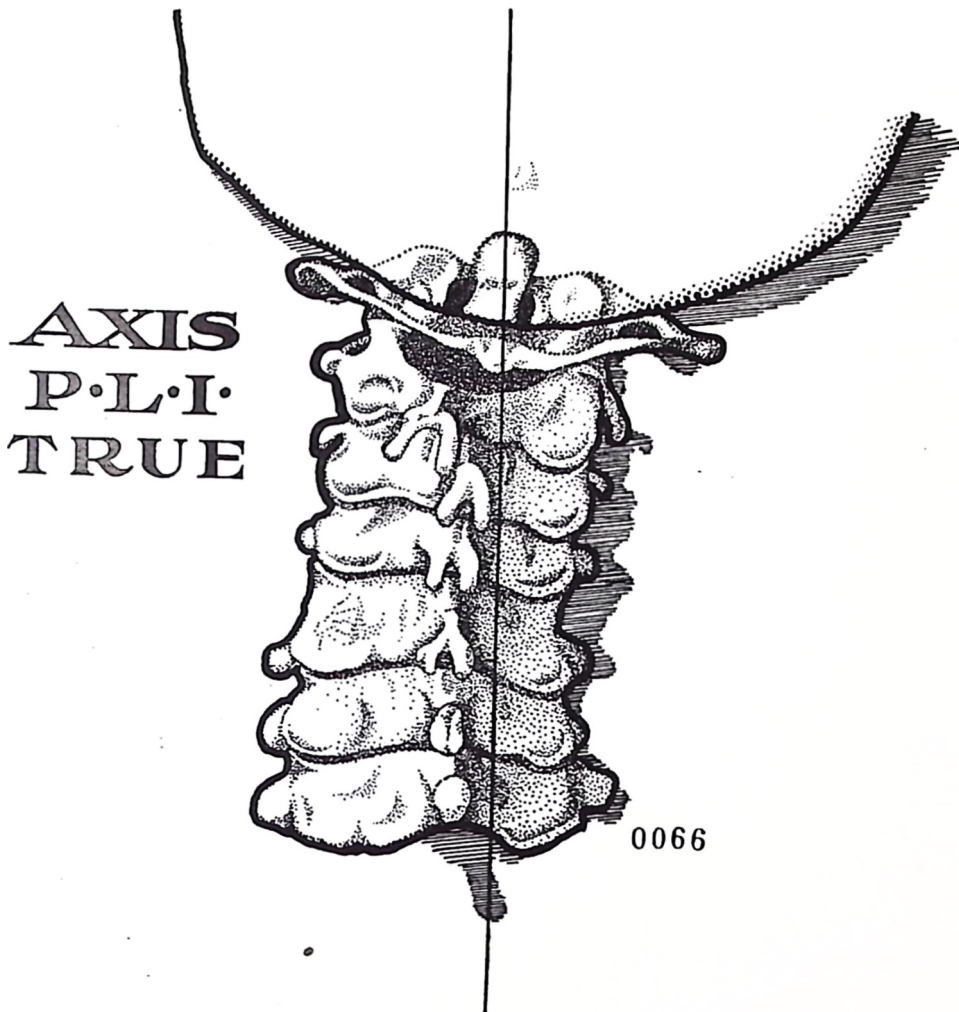


Illustration No. 66

Illustration No. 92.

Schematic pen and ink drawing. Lateral view.

Atlas anterior.

Anterior arch is anterior of normal position with axis.

Anterior arch is neither superior nor inferior.

Posterior arch is neither superior nor inferior.

Which side you would adjust from, would depend upon which side of head, from A-P view, was inferior; favoring the inferior side.

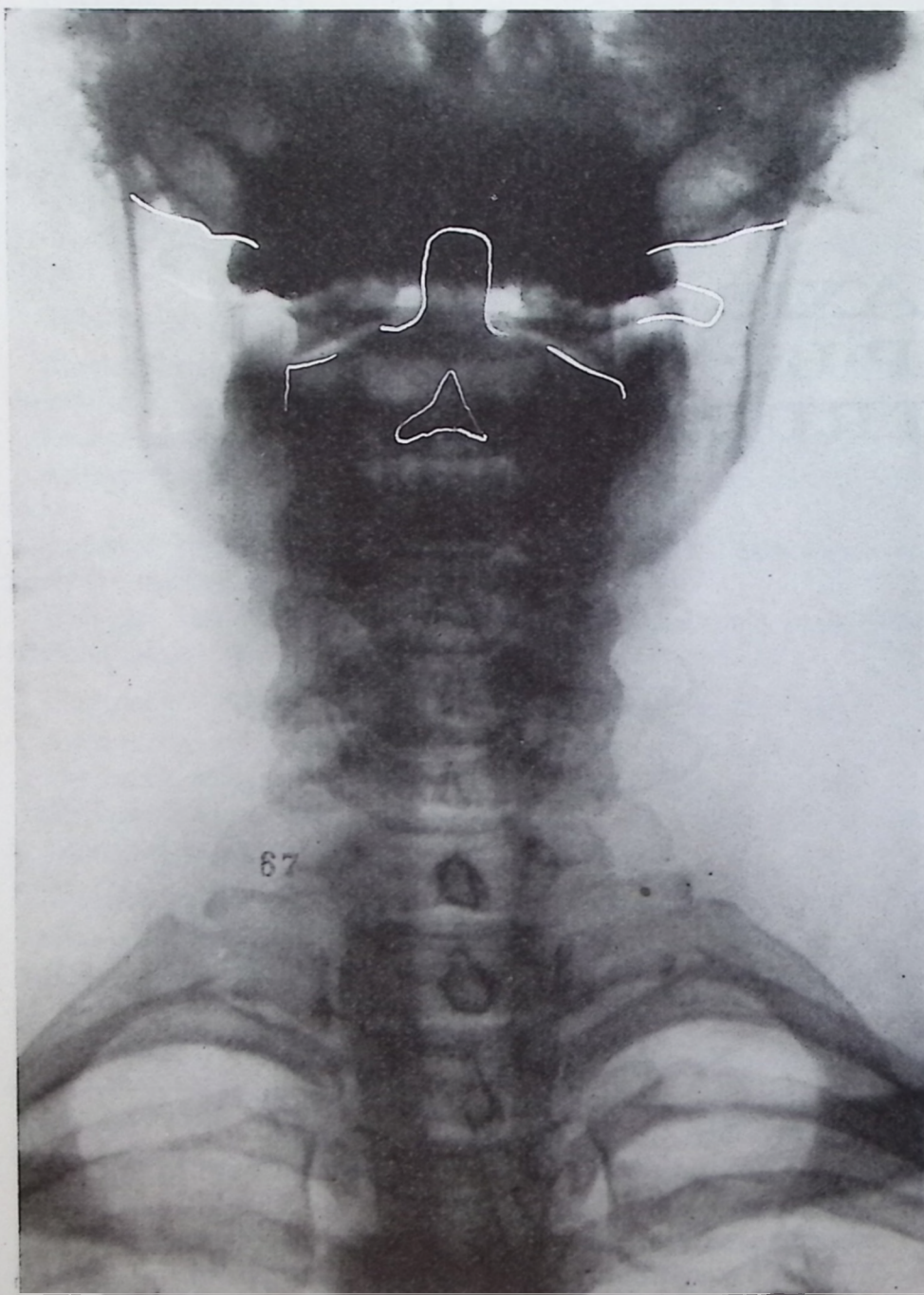


Illustration No. 67

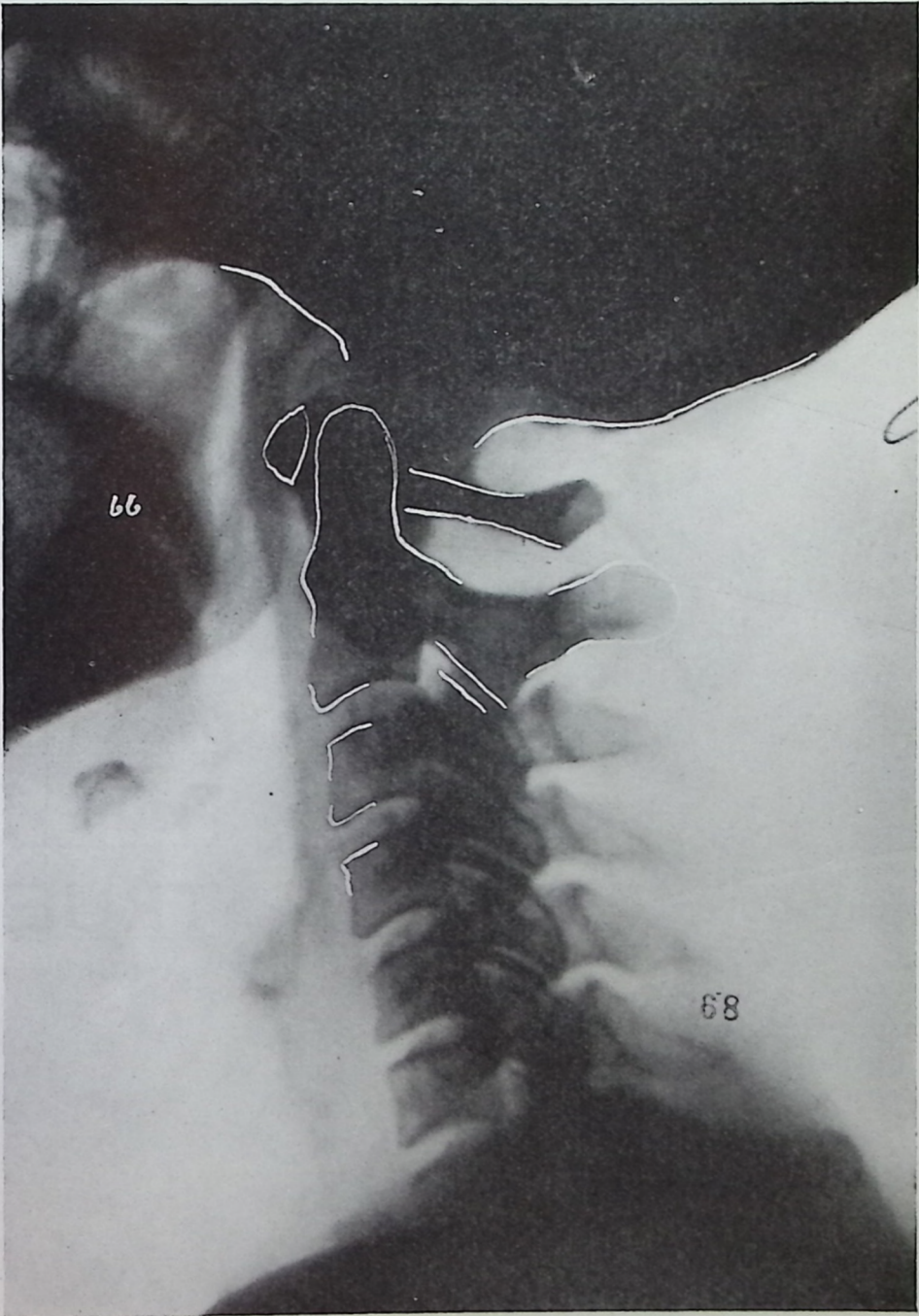
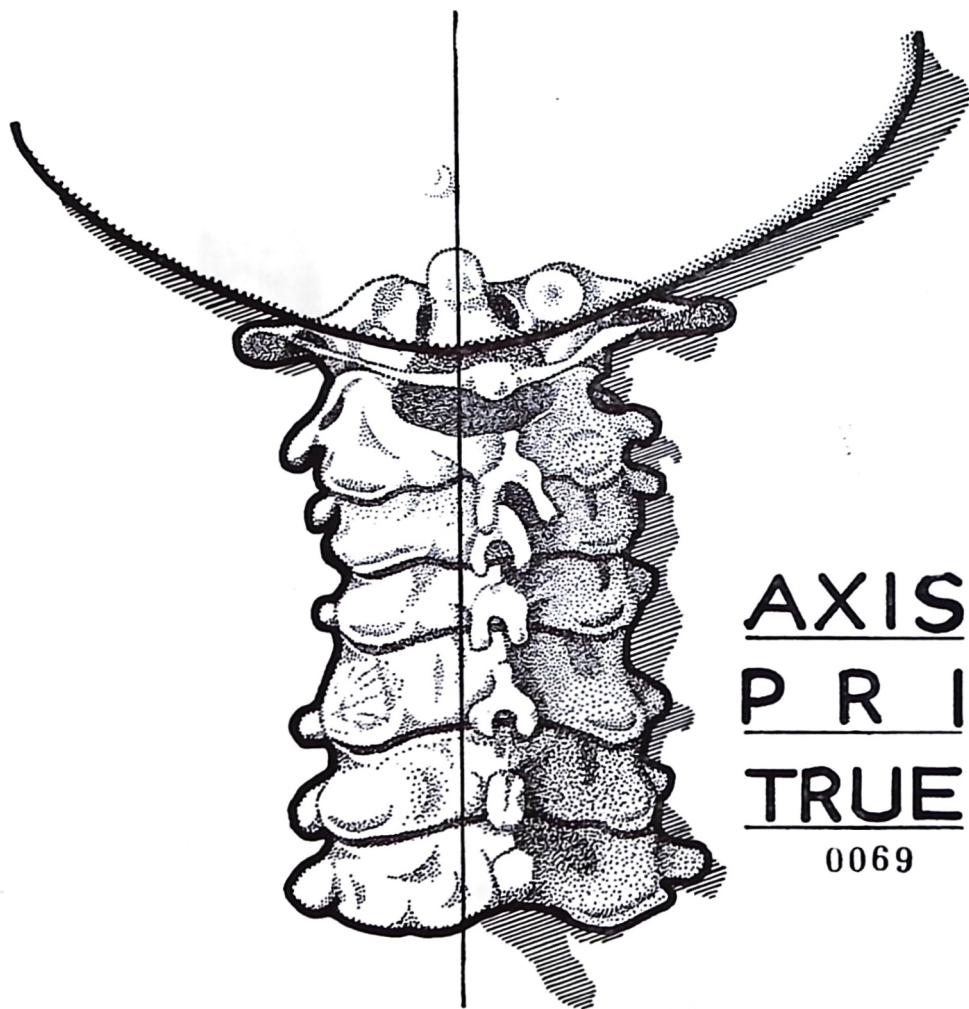


Illustration No. 68



AXIS
P R I
TRUE
0069

Illustration No. 69

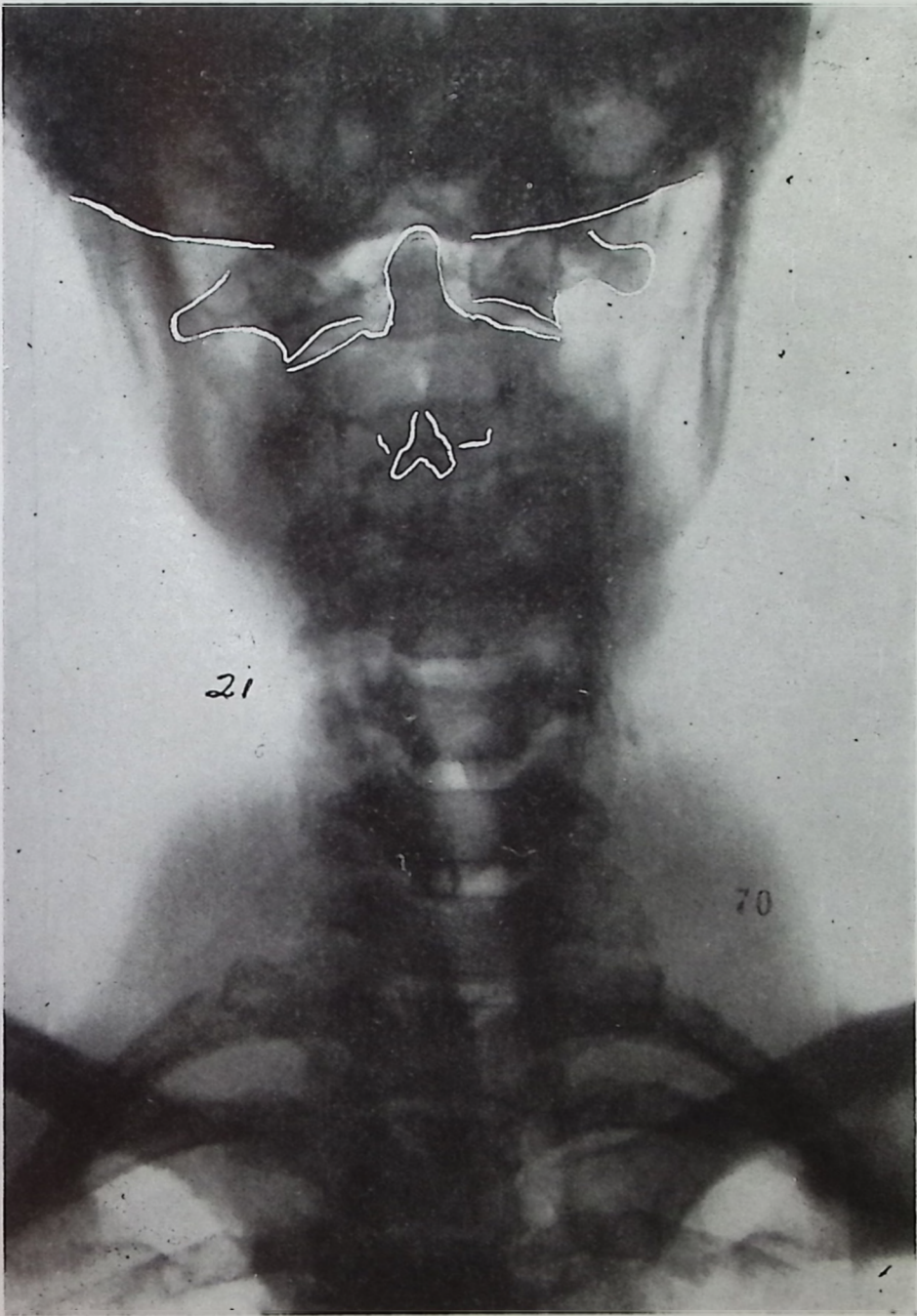


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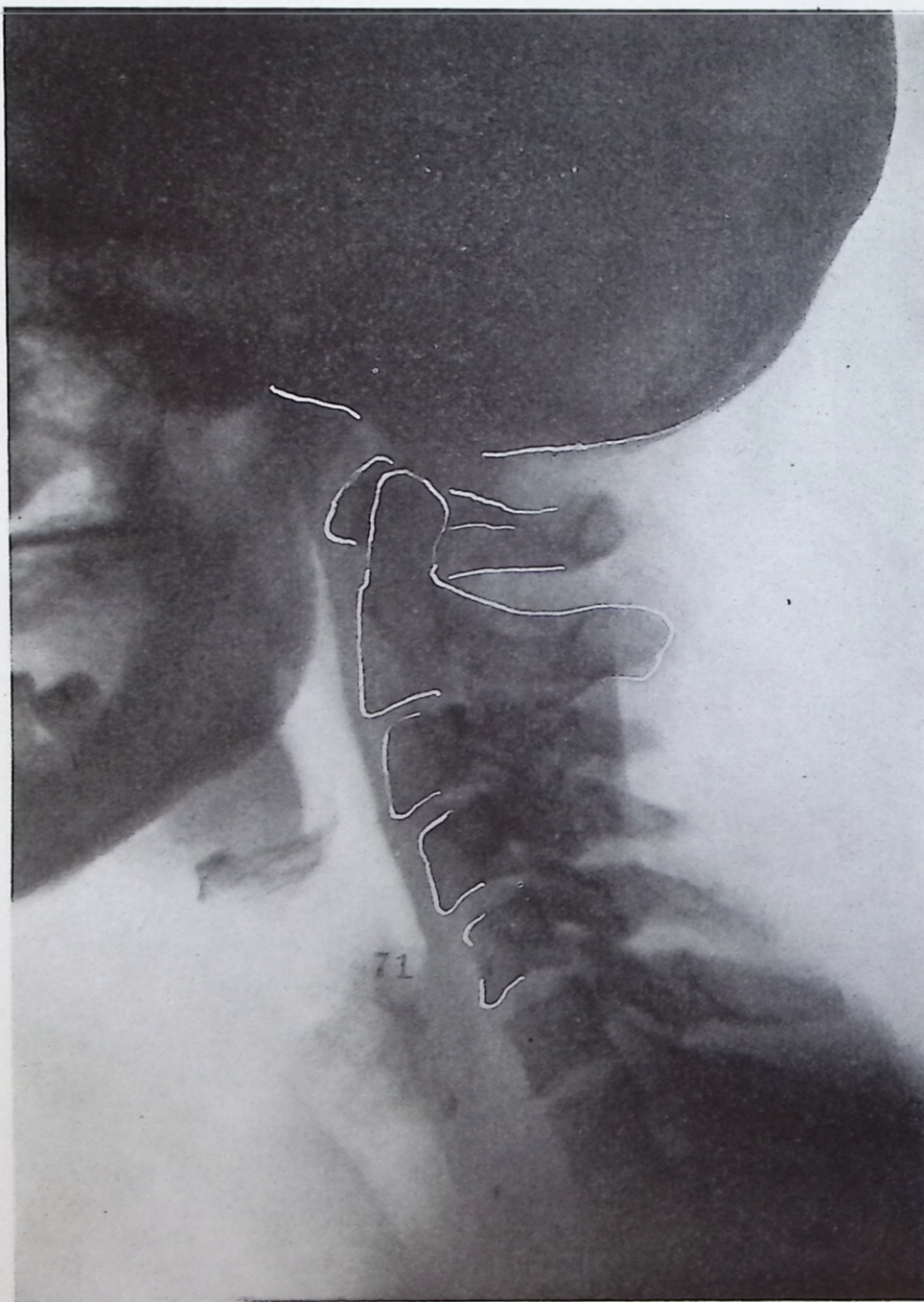


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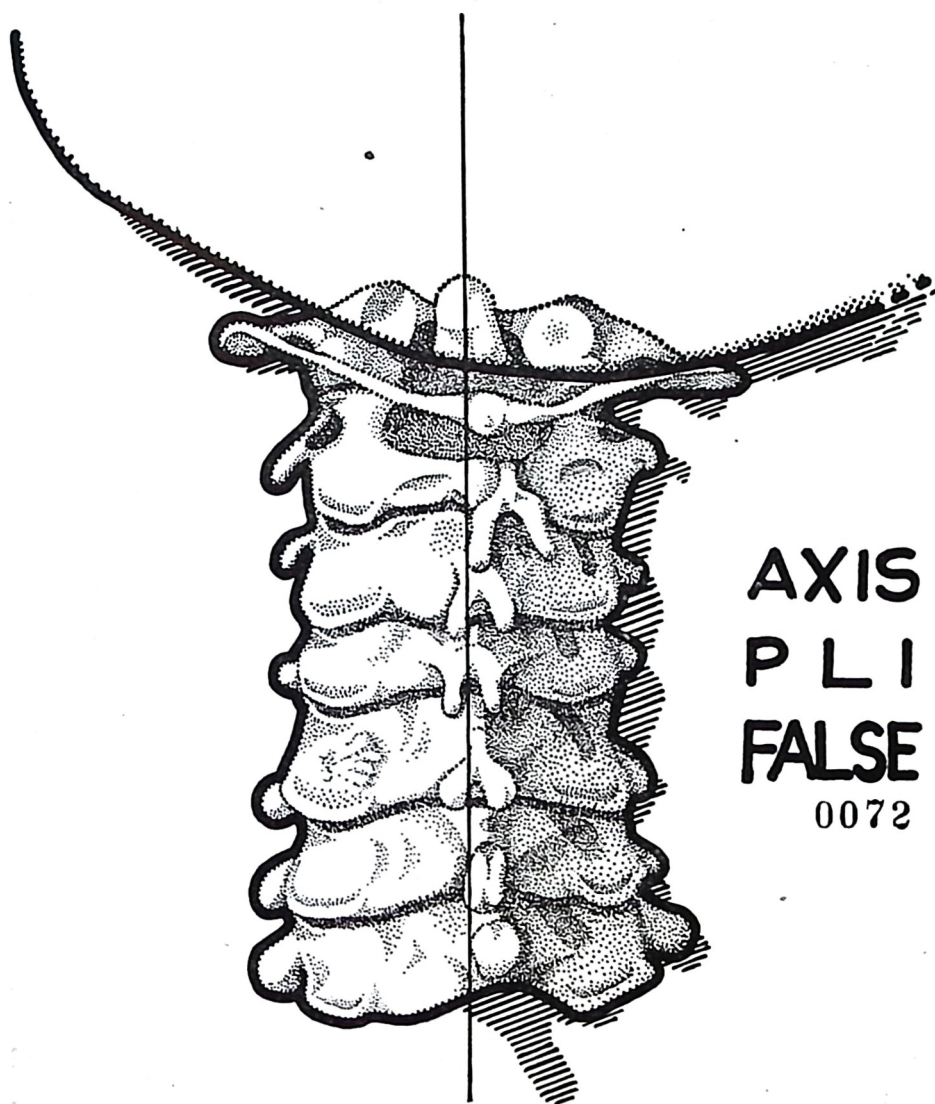


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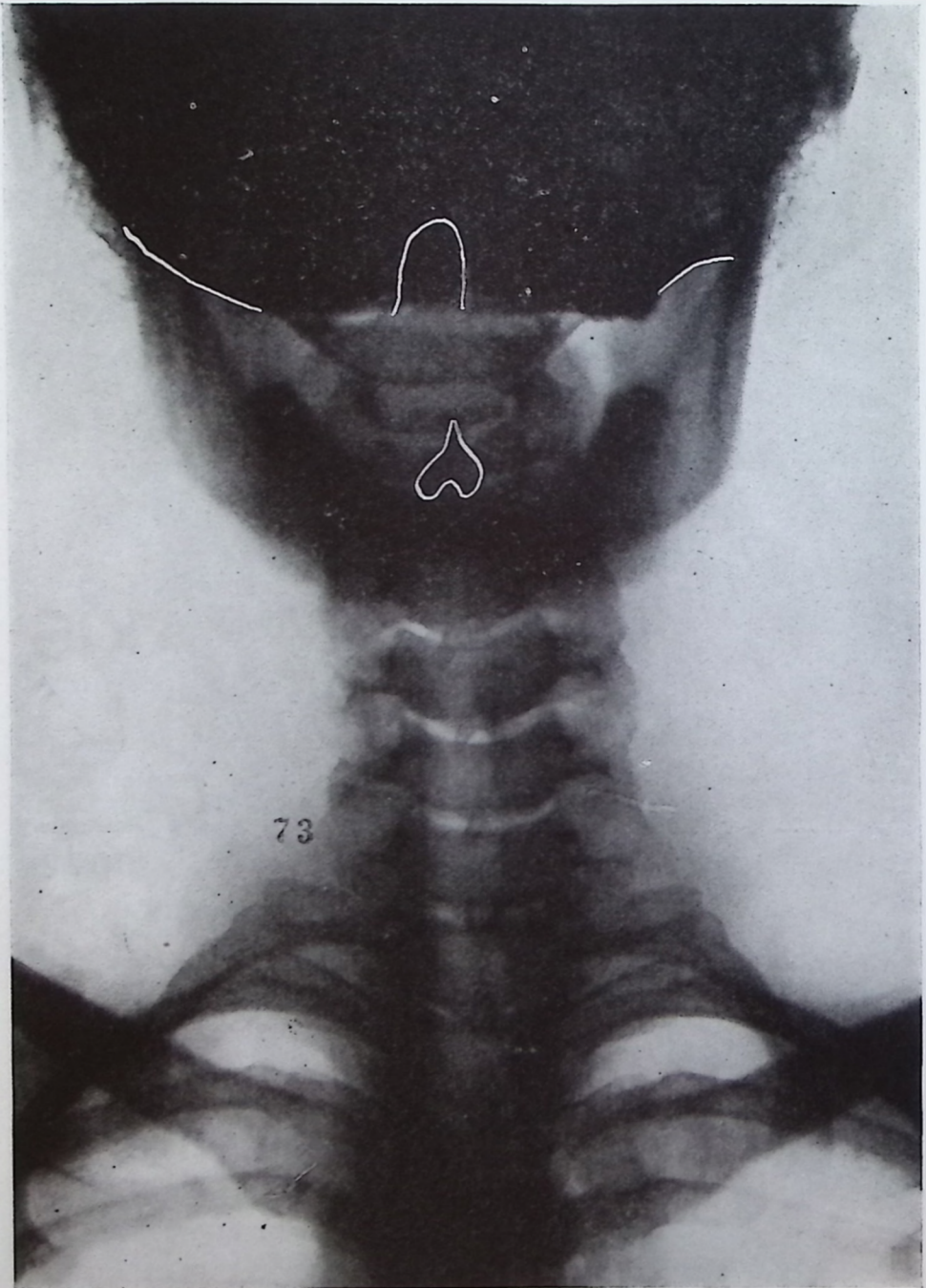


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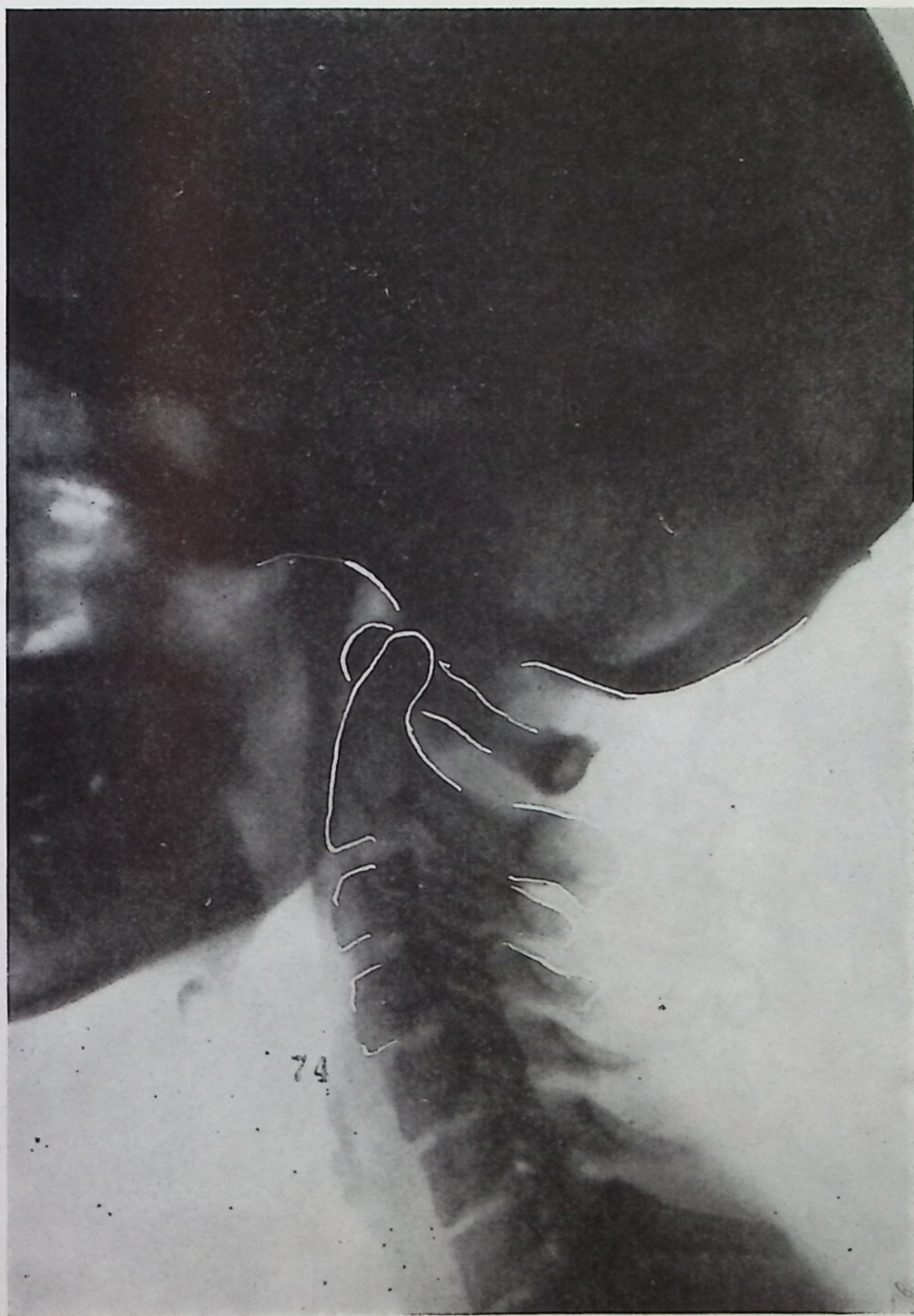


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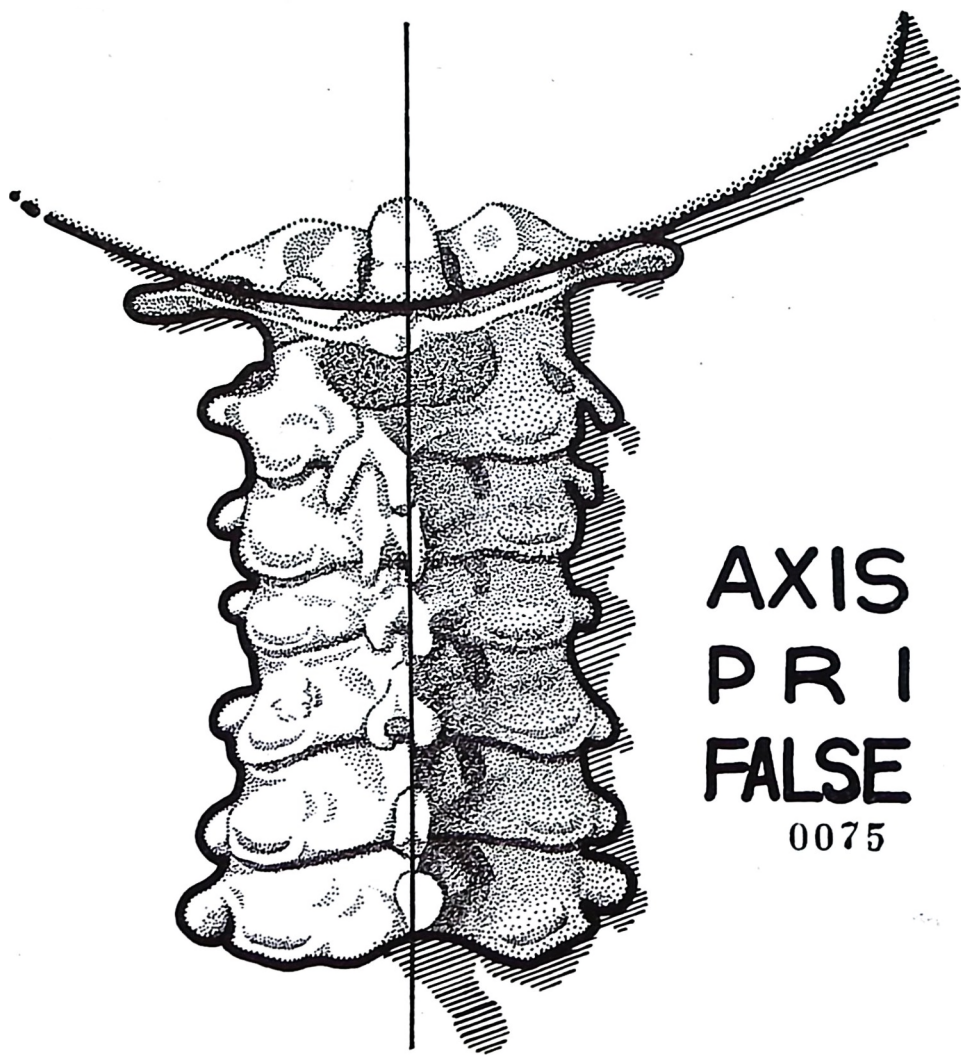


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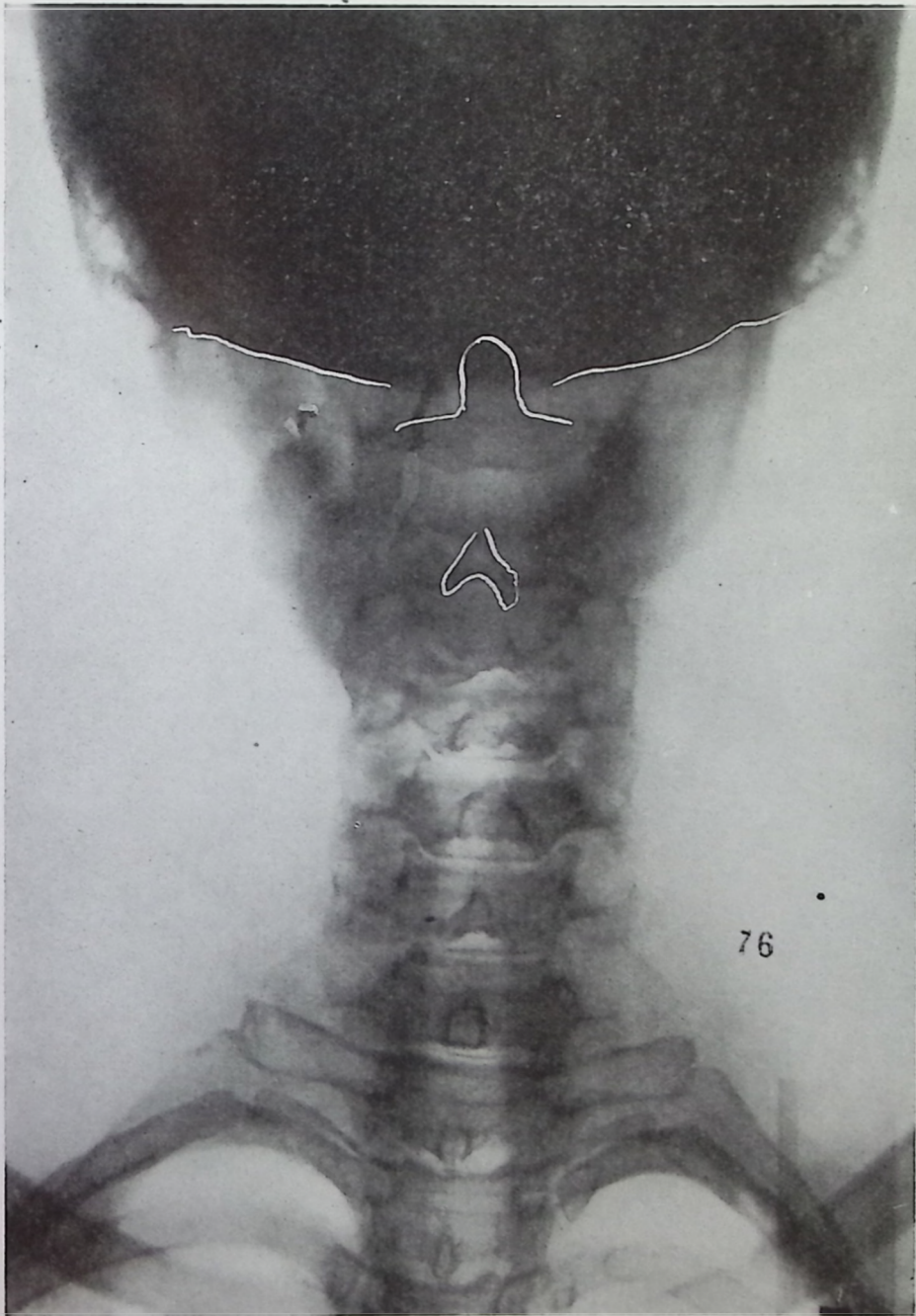


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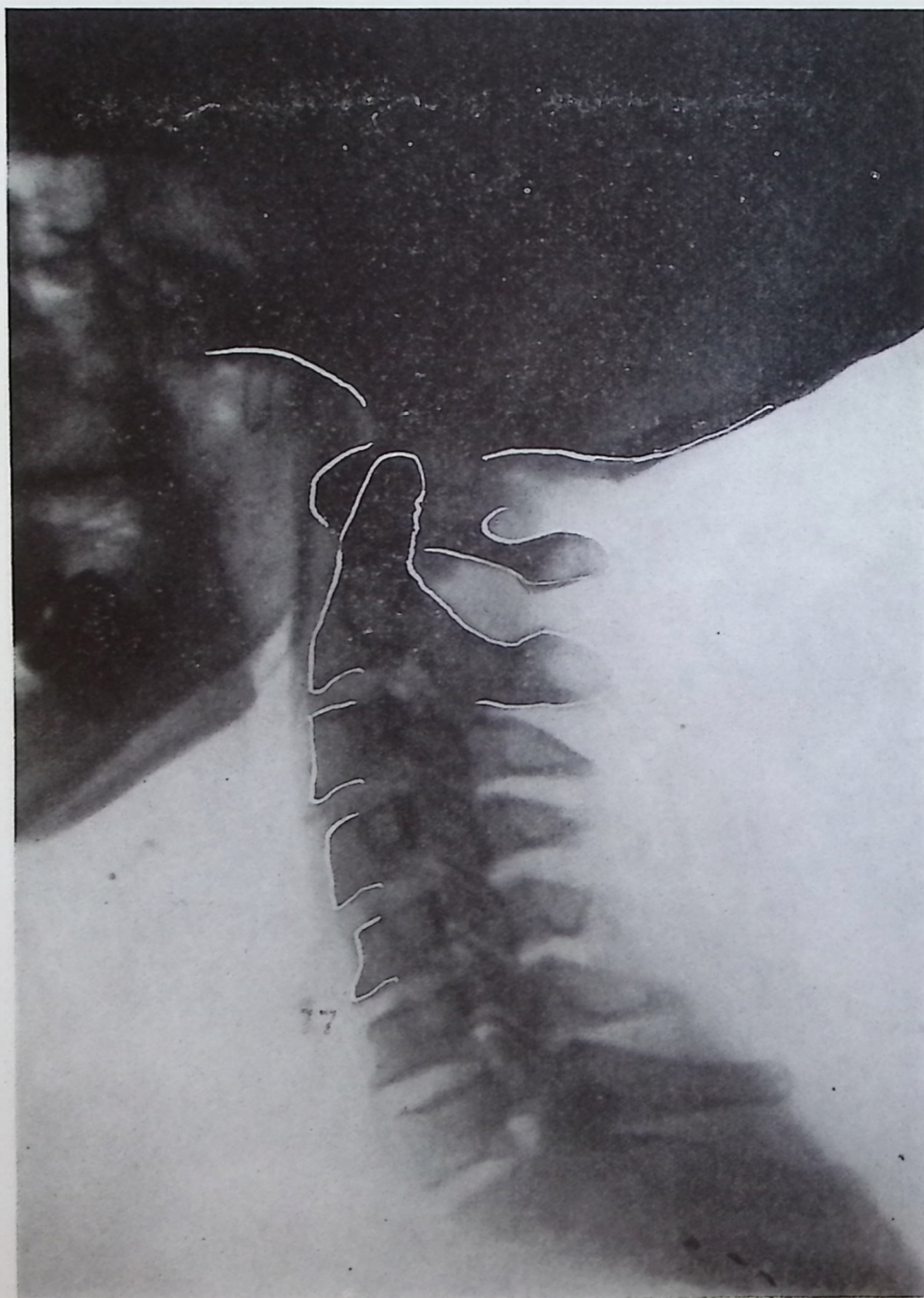
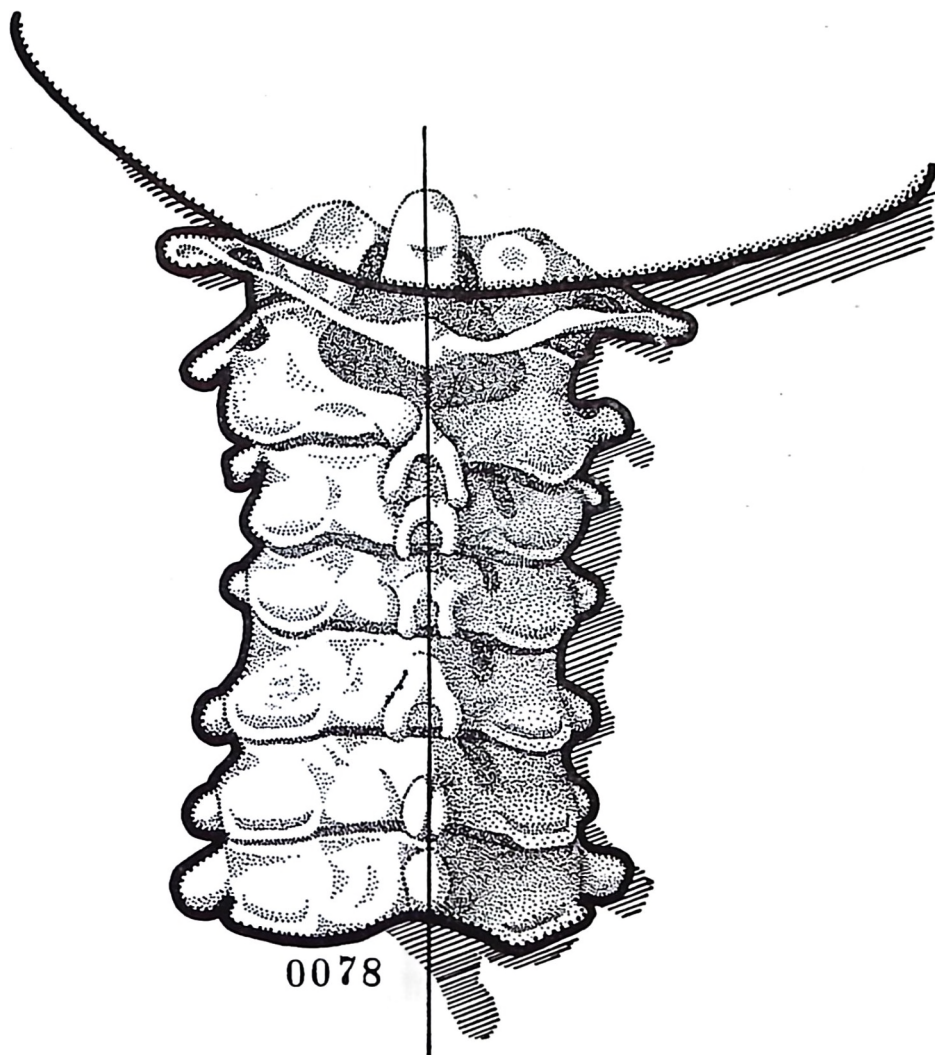
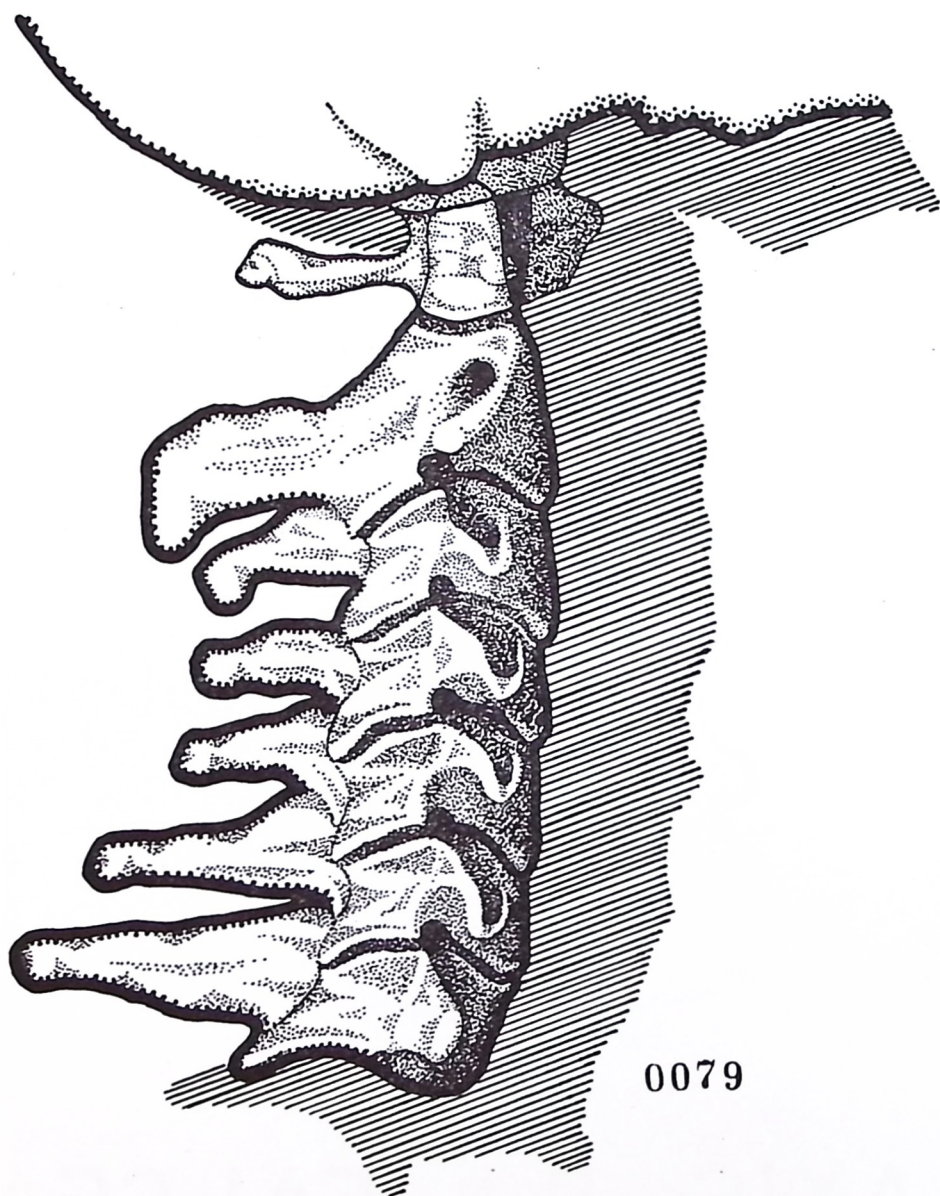


Illustration No. 77



AXIS P I FALSE

Illustration No. 78



0079

AXIS P I

Illustration No. 79

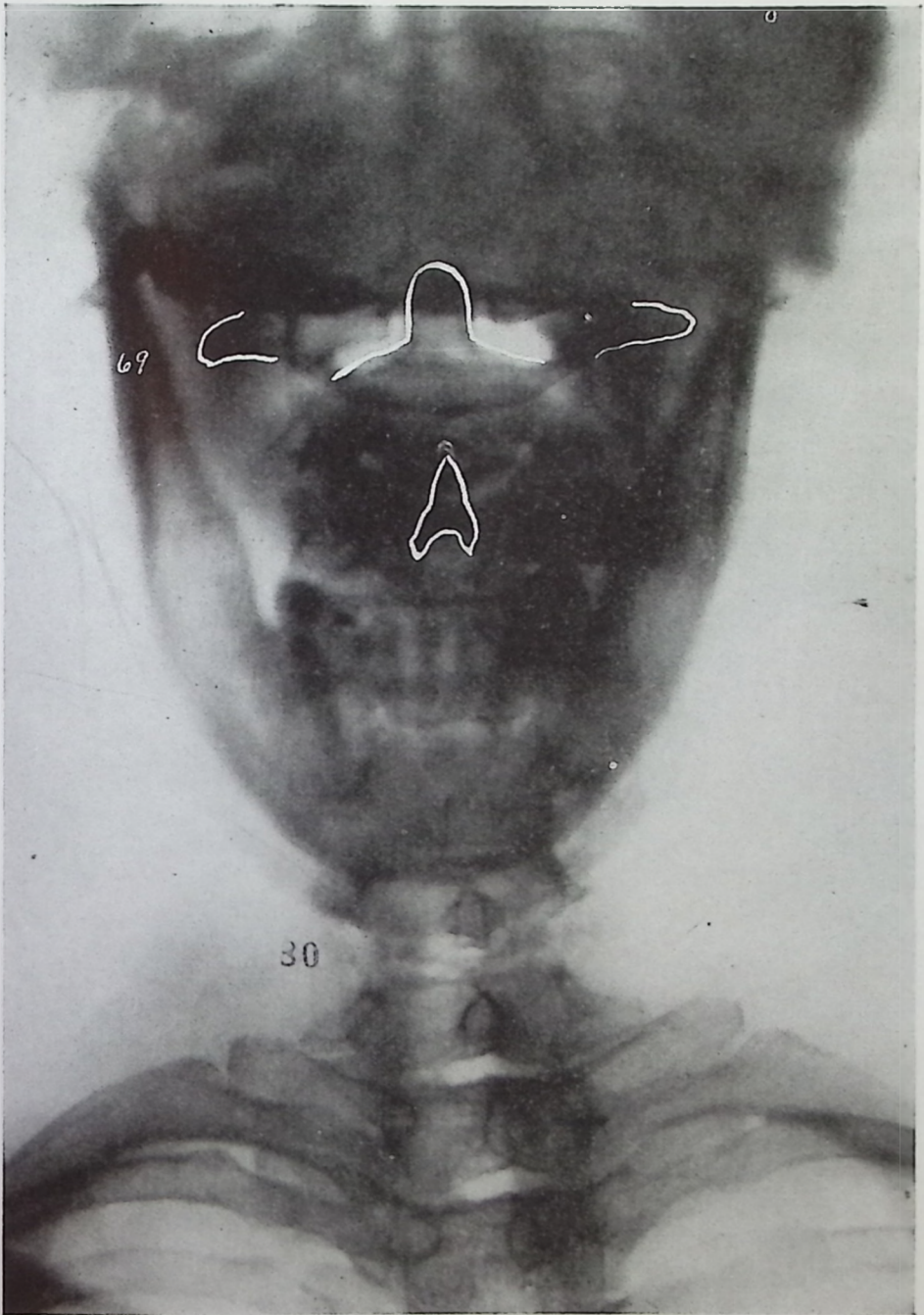


Illustration No. 80

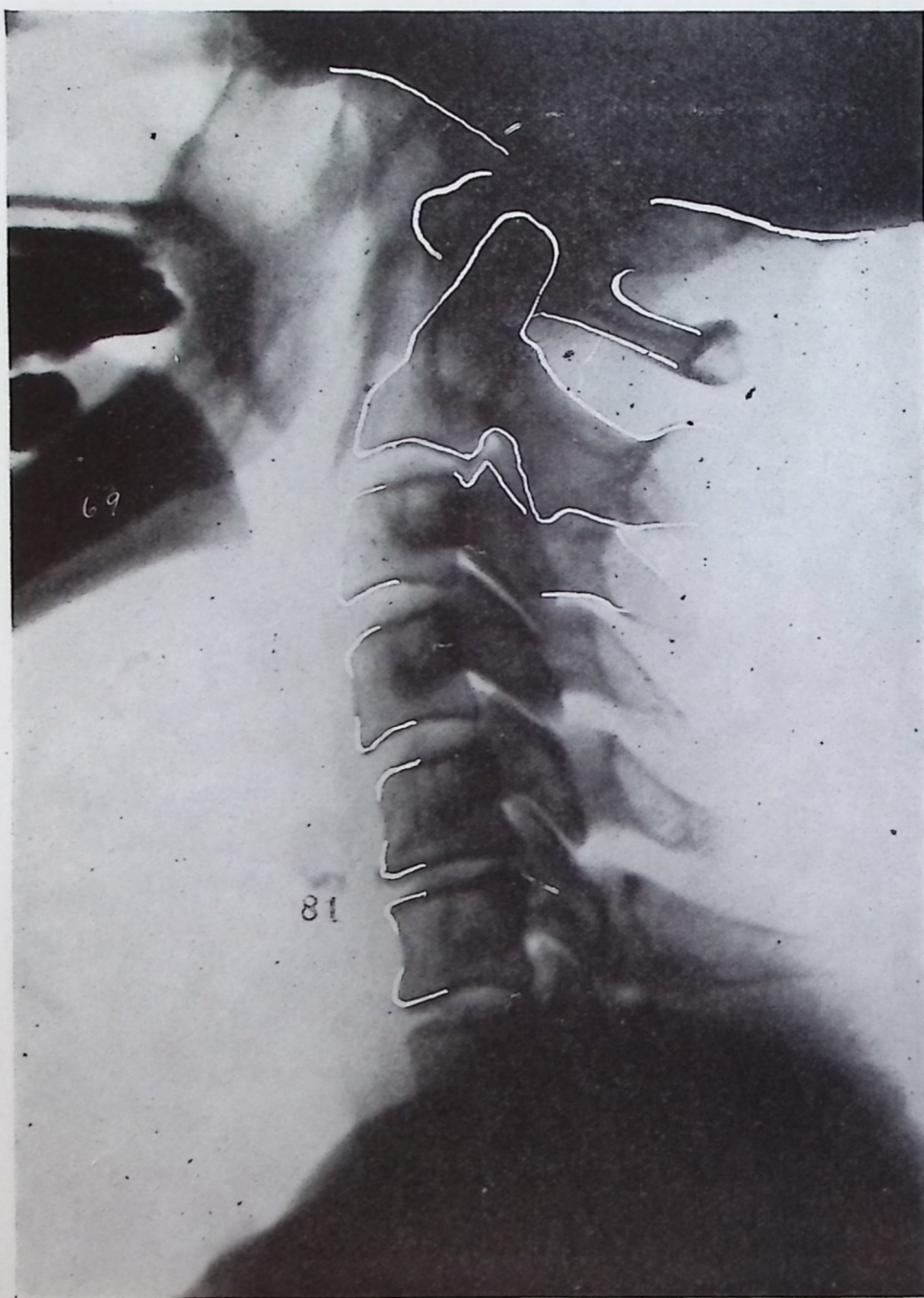
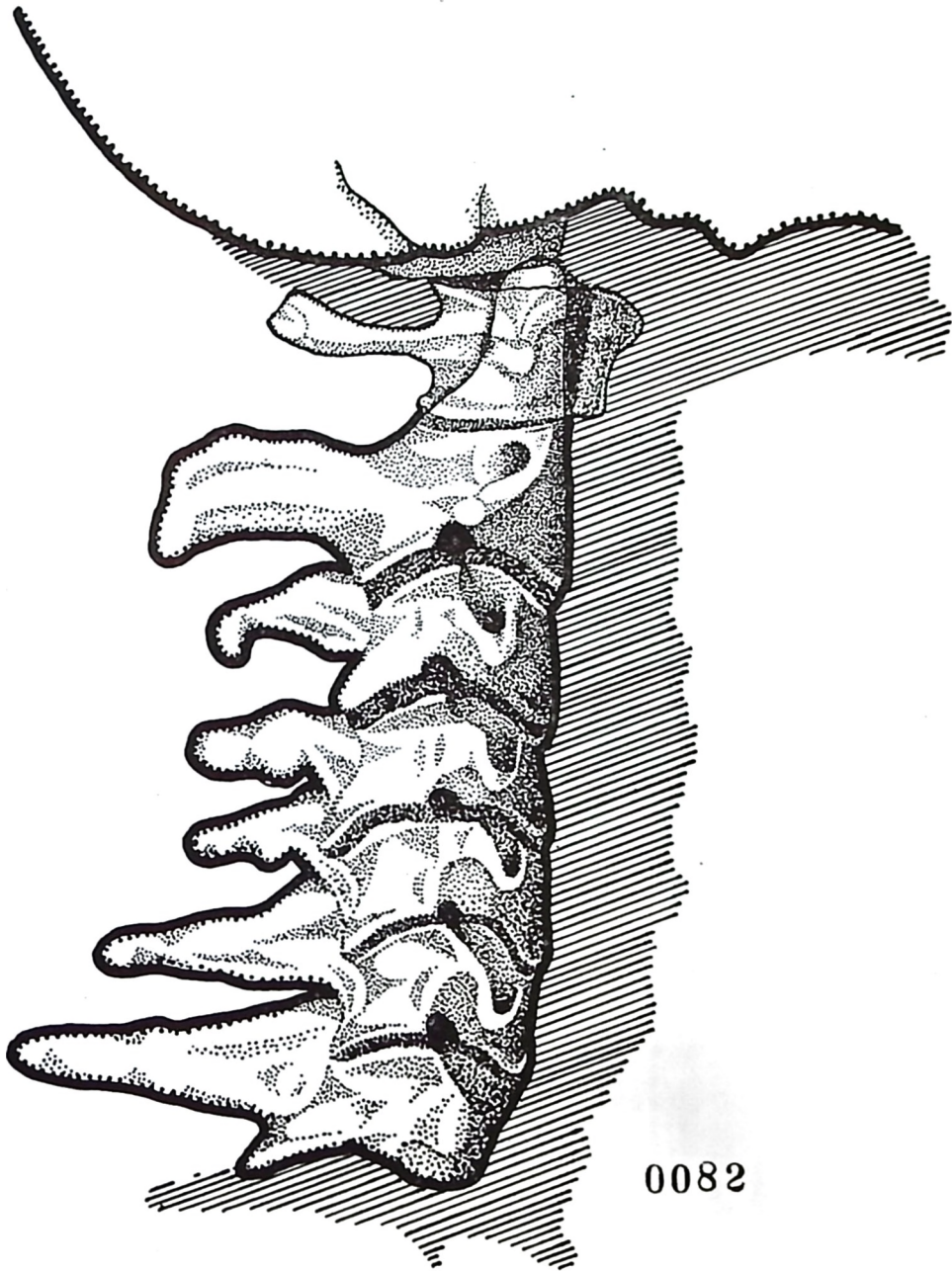


Illustration No. 81



ATLAS A I

Illustration No. 82

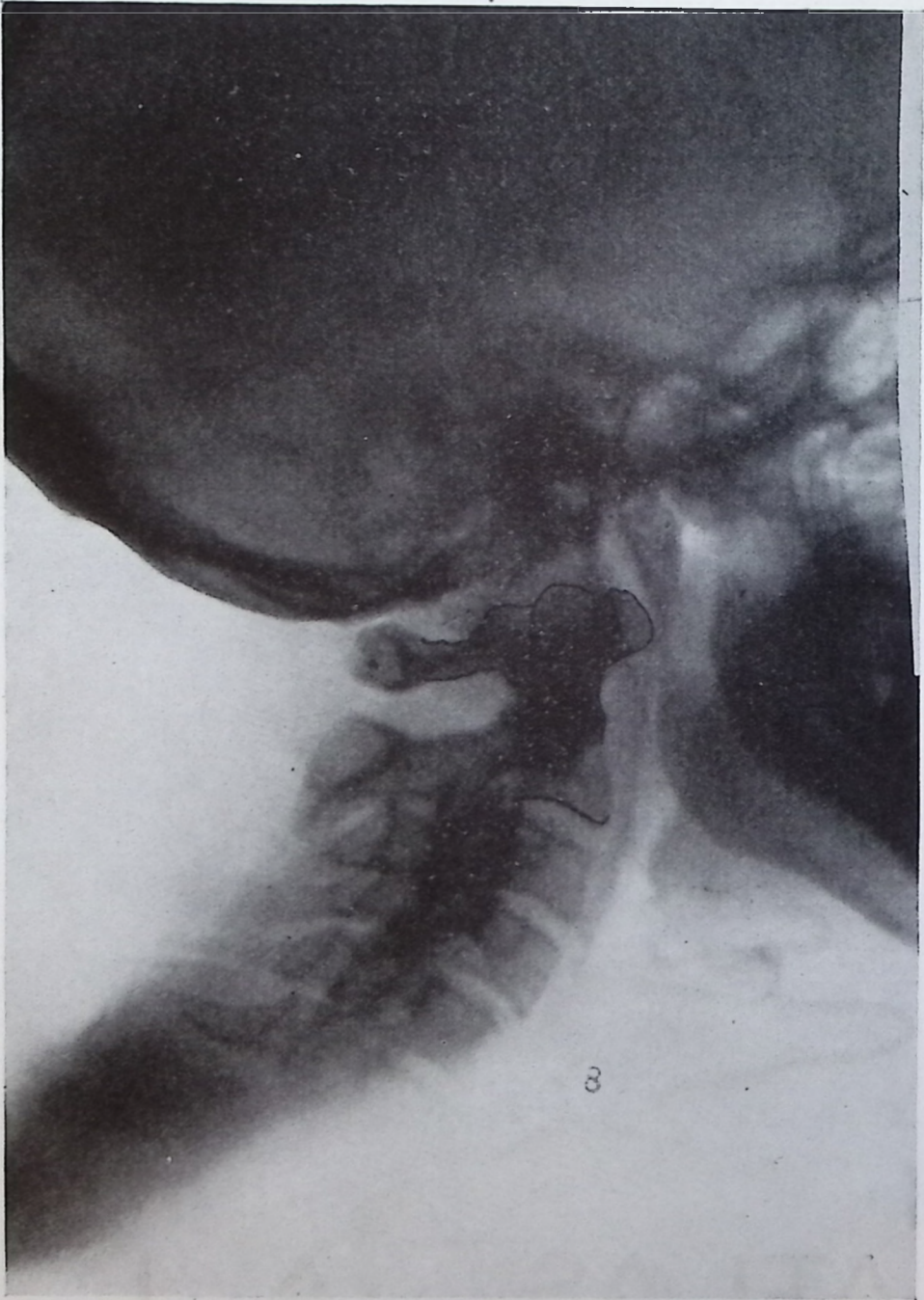


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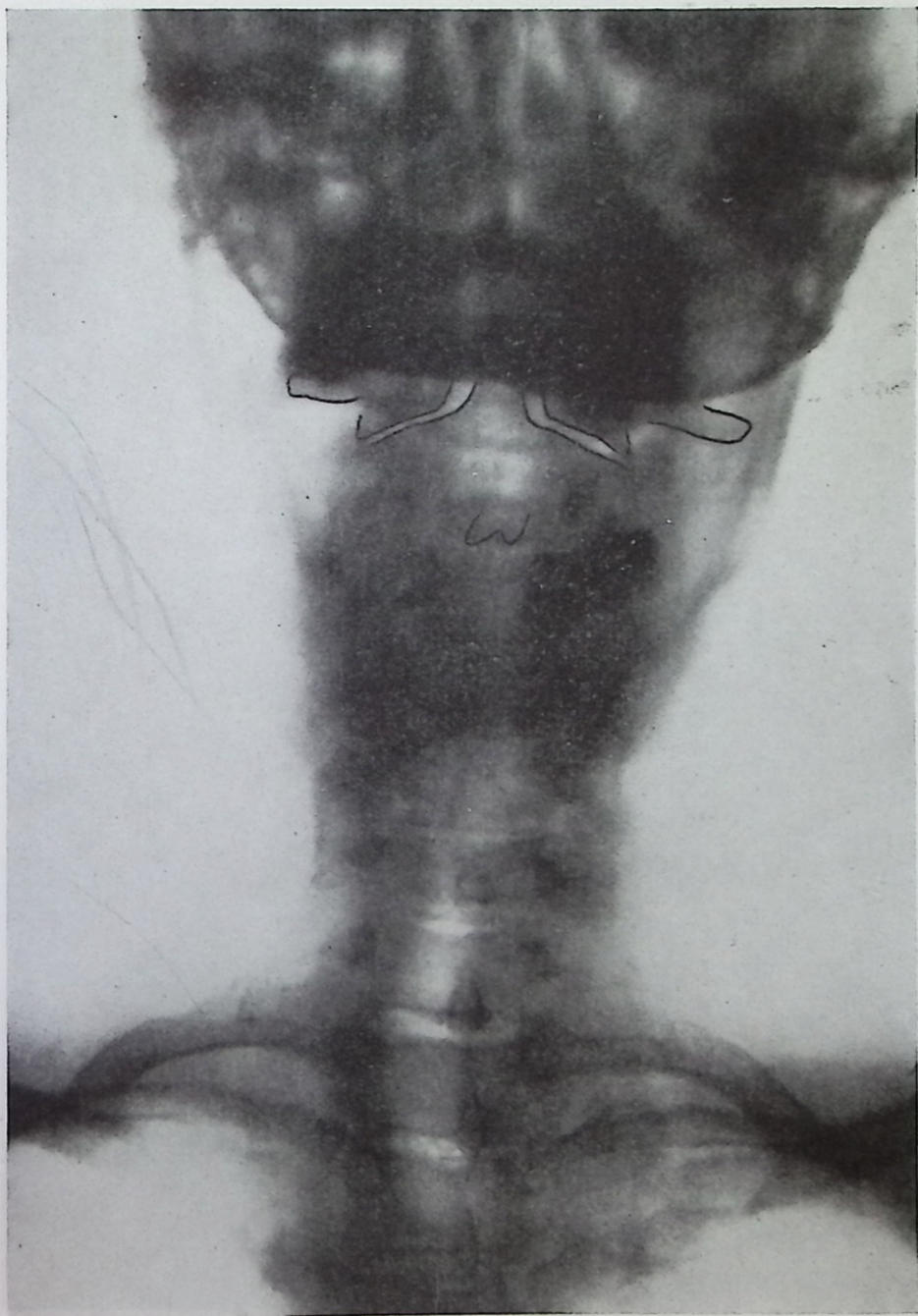


Illustration No. 84

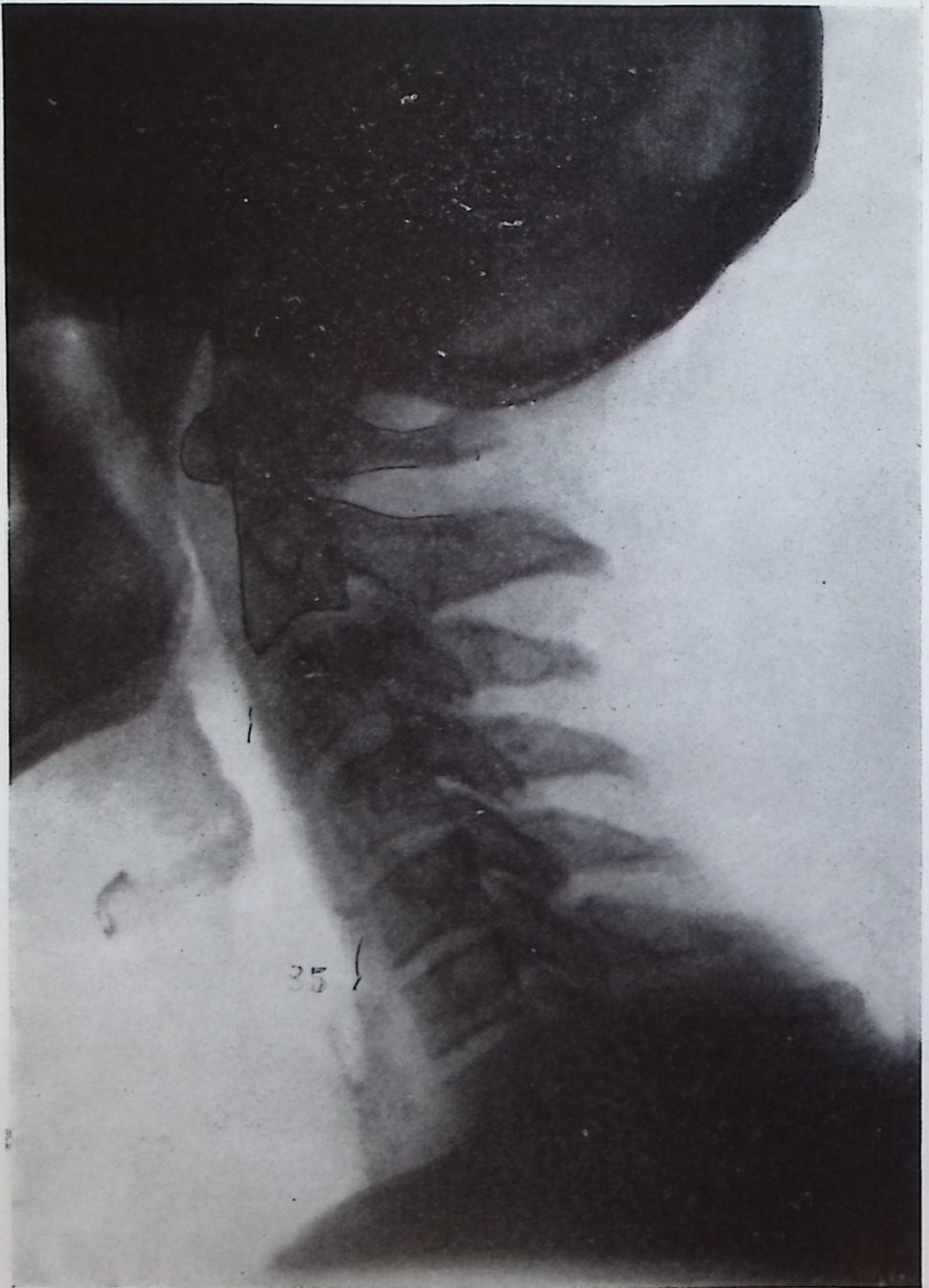


Illustration No. 85

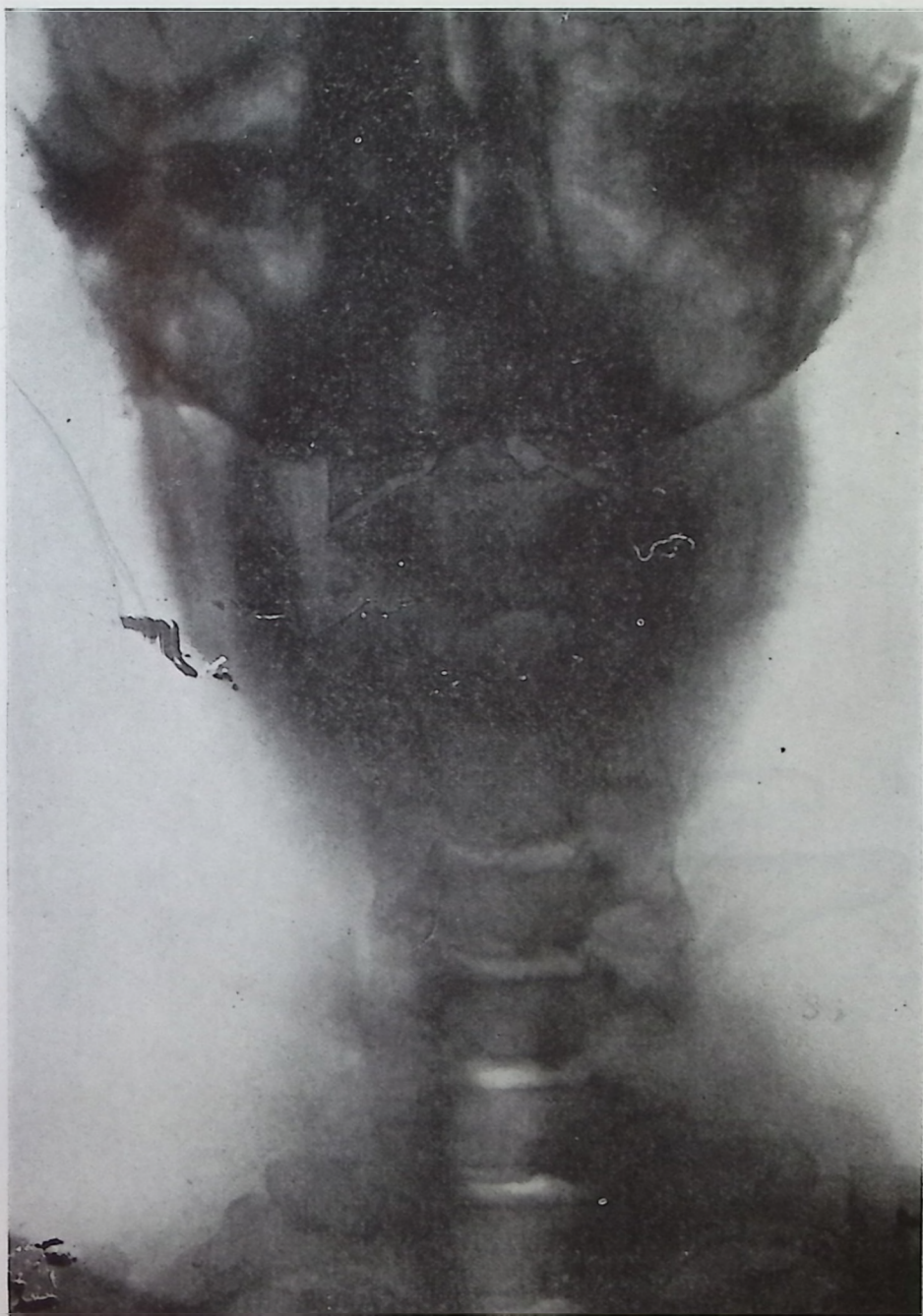
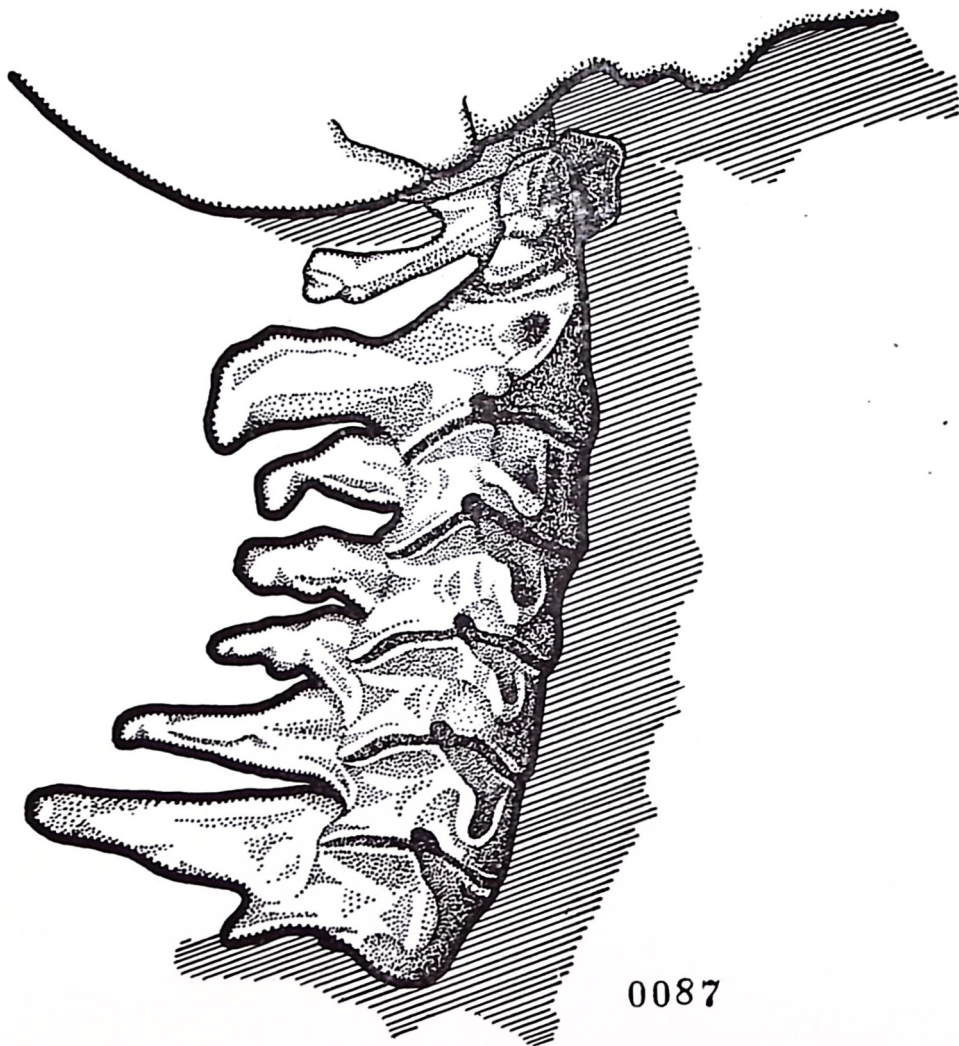


Illustration No. 86



0087

ATLAS A S

Illustration No. 87

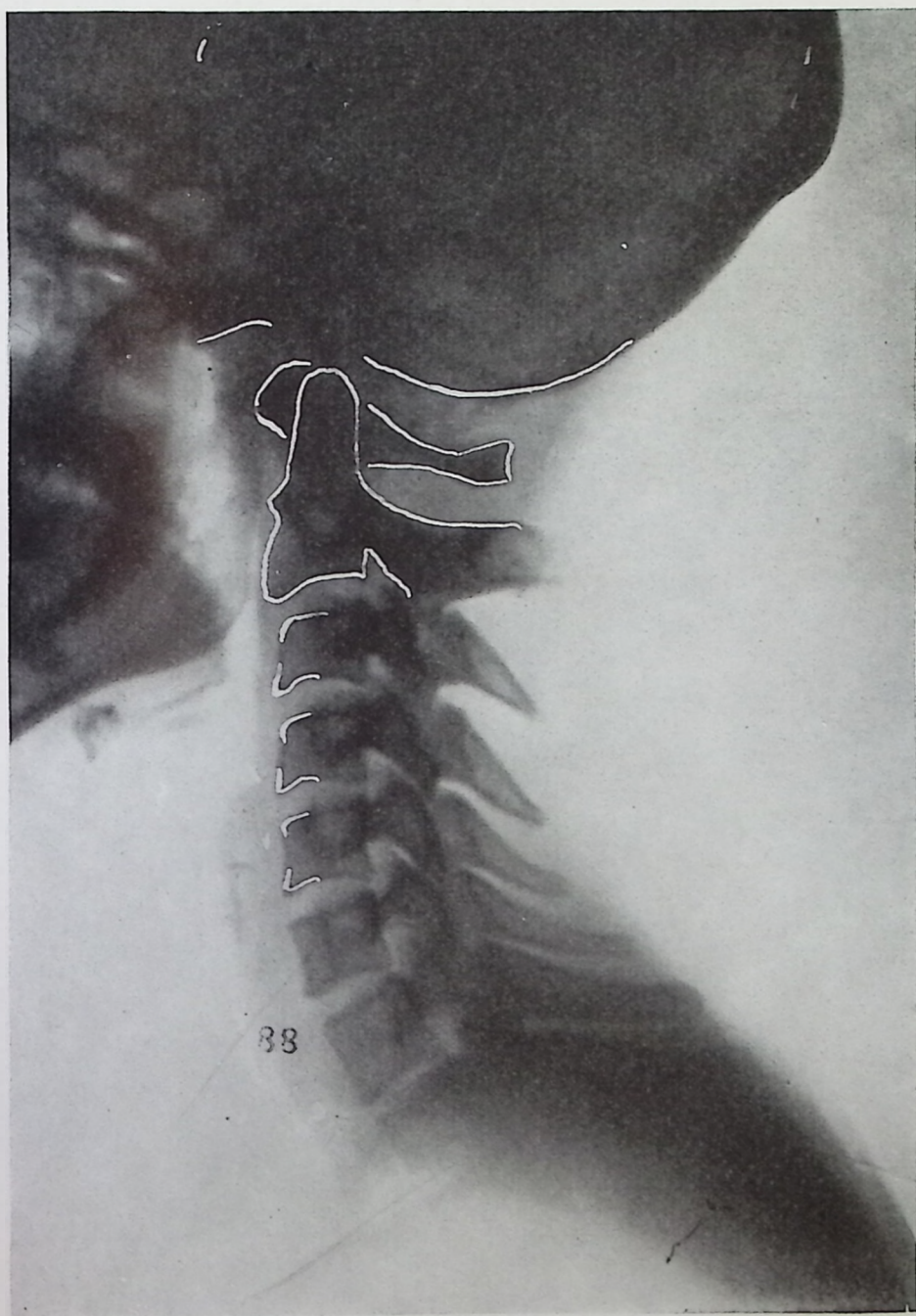


Illustration No. 88

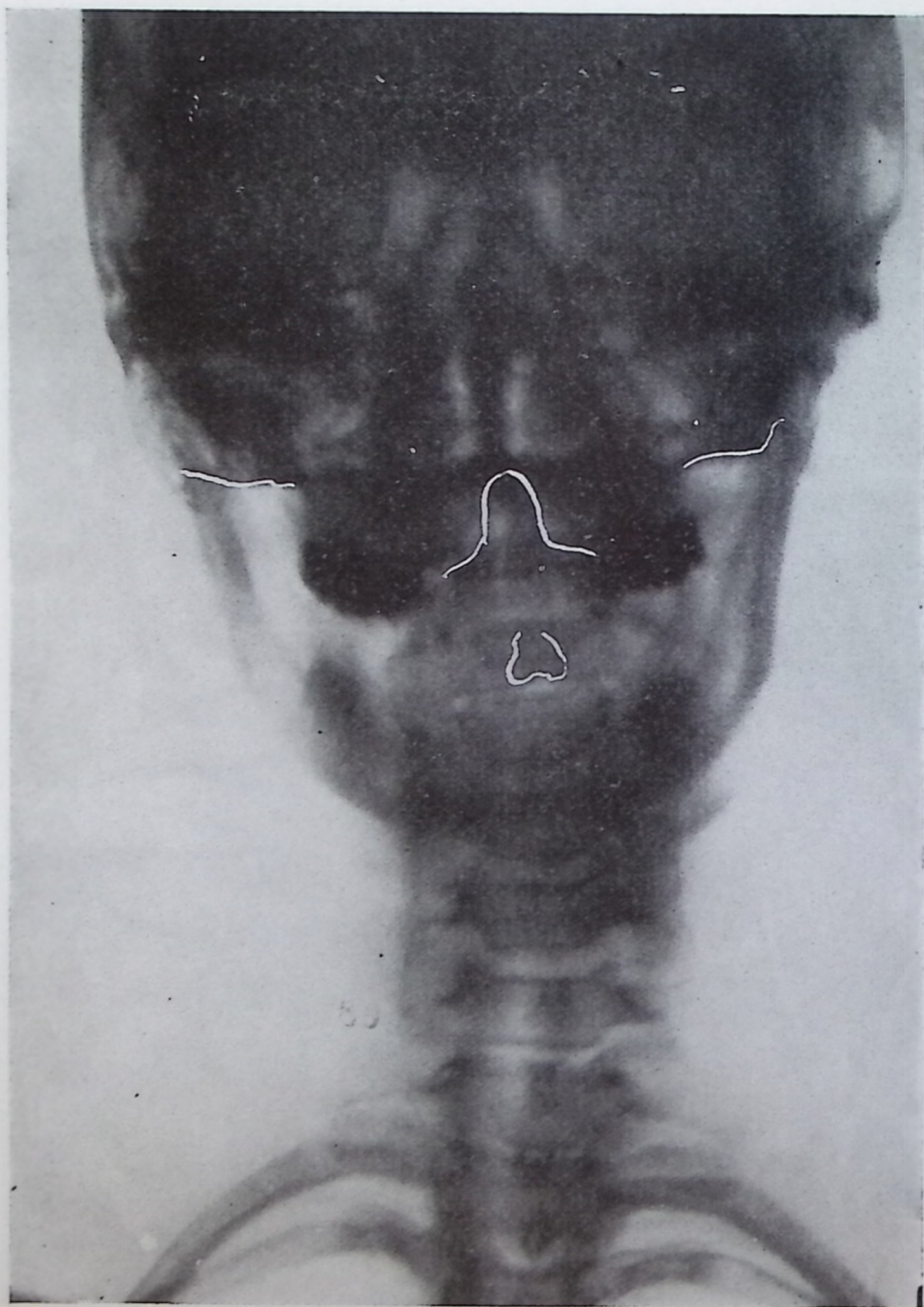


Illustration No. 89

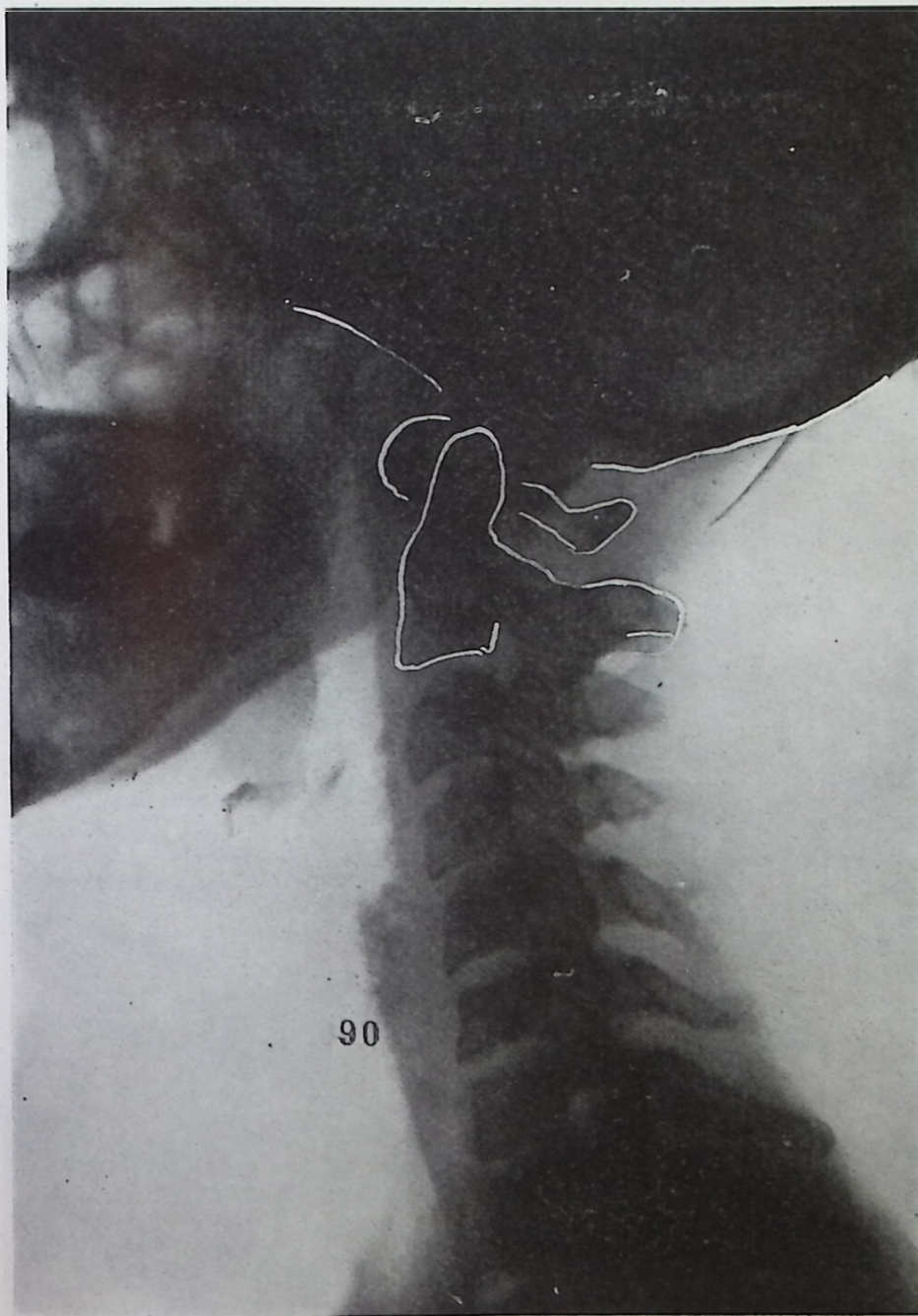


Illustration No. 90

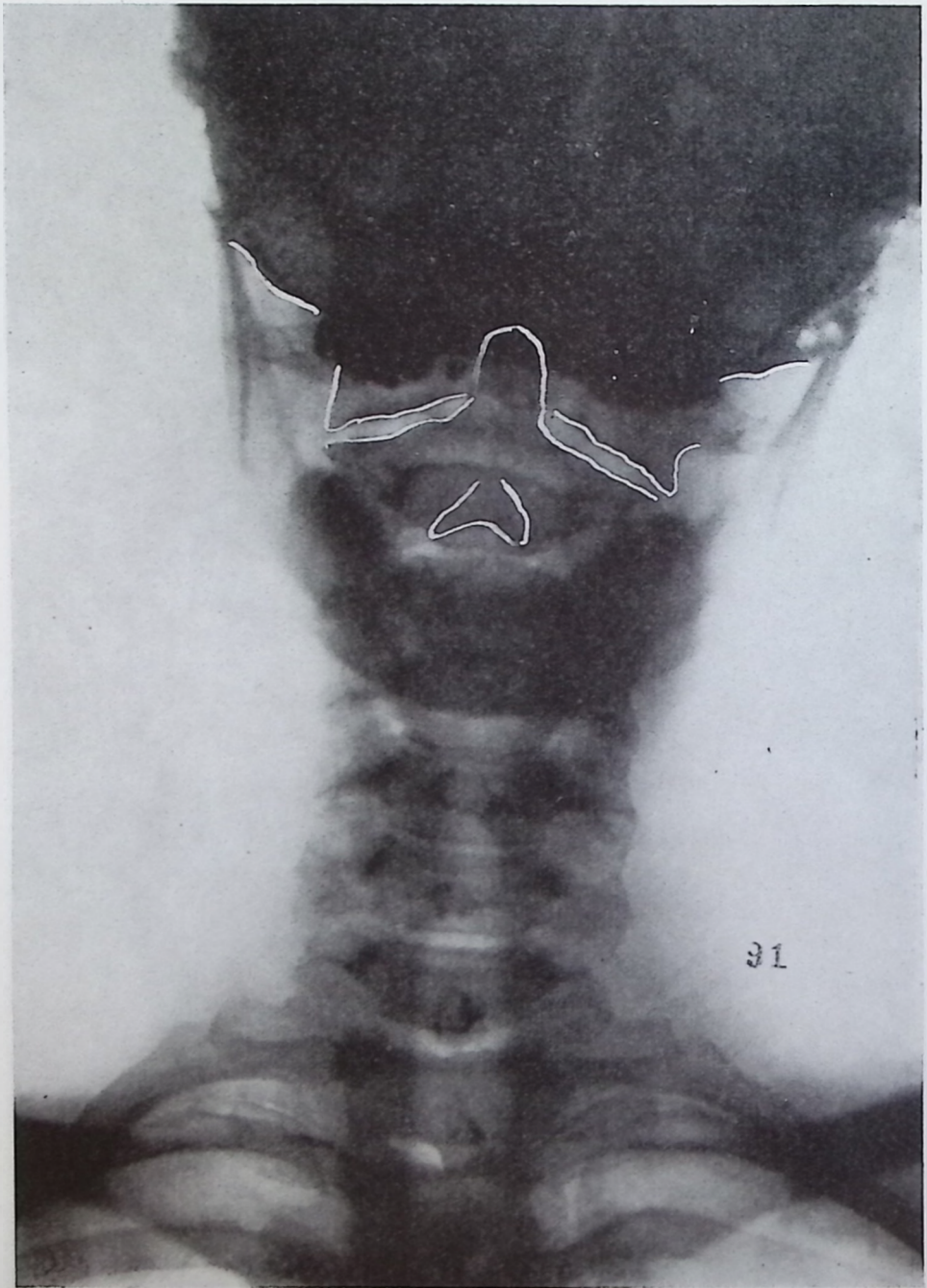
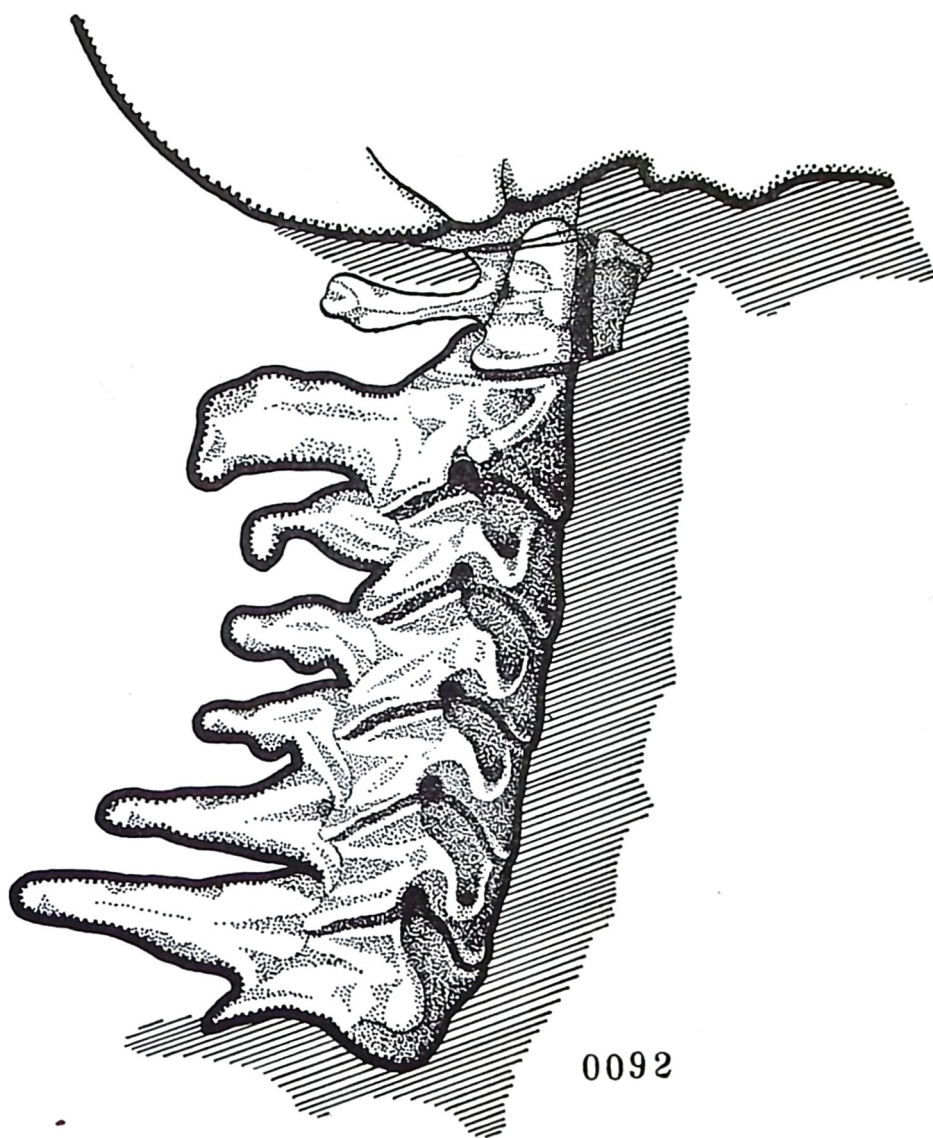


Illustration No. 91



ATLAS A

Illustration No. 92

A VERTEBRAL SUBLUXATION MUST HAVE THREE DIRECTIONS

In former days we palpated and determined whether vertebral "subluxation" was

P
PR or PL
PRI or PLS, etc.

Or, whether atlas was

L or R
LA or RA
LS or LI, etc.

Today we seek a vertebra that is torqued, which means a THREE-direction misalignment, which takes on the firm aspect of always being "torqued" if it has three directions in its misalignment; and if it has three directions in its misalignment, it IS a torqued subluxation. The question then arises, if to BE a subluxation it MUST be misaligned in THREE directions; where can we HAVE misalignments of THREE directions? WHY do we think of THREE directions and rarely, if ever, find one or two directional misalignments possible? WHY do we affirm that it is IMPOSSIBLE to have THREE direction misalignments in lumbar, dorsal, or cervical regions except at atlas or axis? Why do we affirm that the ONLY place in a spinal column where there CAN exist three-directional misalignments is at occiput, atlas, and axis?

If a vertebra becomes misaligned (note I do not say "subluxated") ONE direction, it tends to AND CAN correct itself under rest, relaxation, either naturally or artificially induced. If a vertebra becomes misaligned in TWO directions, it still CAN correct itself, under rest, relaxation, either naturally or artificially induced, altho it will do so with more difficulty. ONE or TWO directions cannot introduce occlusion, pressure, or interference. If a vertebra becomes subluxated (note that I do not say "misaligned") THREE directions, it cannot correct itself under INTERNAL induced conditions, be they rest, relaxation, either naturally or artificially induced. Only an EXTERNAL intentional application of an EXTERNAL force can overcome the condition induced by the accidental application of an EXTERNAL

force which created the three-direction subluxation. THREE direction subluxation DOES introduce occlusion, pressure, and interference.

Can there be a SUBLUXATION with its necessary four elements, viz.,

1. misalignment with co-respondents above and below
2. occlusion of foramen thru which nerves pass
3. pressure upon nerves
4. interference to transmission of mental impulse supply—

of ANY vertebra that has LESS THAN THREE different abnormal directions from its normal position? Can there be A SUBLUXATION of a vertebra, with its necessary four elements present, as stated, IF it has only one or two but "less than three different abnormal directions from its normal position"? Can there more or less permanently exist a kink, twist, wrench, or torque without there being present ALL THREE "different abnormal positions from its normal position," simultaneously perverted? If an INTERNAL concussion of forces concusses a vertebra out of normal position, in one or two "different abnormal directions from its normal position," will it remain more or less permanently out of alignment and constitute itself a subluxation; as a kink, twist, wrench, or torque and produce ALL FOUR elements listed, which ARE NECESSARY to regard it as a vertebral SUBLUXATION causing dis-ease?

In analyzing A-P and lateral cervical spinographs, cases appear that are border-line atlas subluxations, where atlas rules do not clearly or completely apply, where axis rule more aptly does apply. Border-line atlas cases appear to have only TWO directions of subluxation, viz.,

- laterality and superiority or inferiority (RS, RI, or LS, LI,) without inferiority (I).
- laterality and anteriority (RA or LA) without superiority (S) or inferiority (I).

Atlas appears wedge-side-slipped with anterior arch superior or inferior WITHOUT seeming to be anterior; or atlas appears wedge-side-slipped with anterior arch seemingly level and yet be anterior of odontoid. In each instance of a border-line case, evidence shows head is more pronounced inferior or superior on

posterior, with more inferiority of axis, making contrast of atlas between occiput and axis.

Apparent absence of third direction is because TWO directions are oft-times SIMULTANEOUSLY ONE direction. Example: axis is "posterior" AND "inferior." Axis CANNOT be "posterior." Inferior and anterior locks prevent its being subluxated "posterior." When axis spinous process IS inferior (because of compression of spinous processes of cervical vertebrae) odontoid IS posterior, thus combining TWO directions actually into ONE, one of which is and the other of which is not, yet is. Same is true with anterior arch of atlas. When it is superior, it is anterior; one single movement, yet two directions if divided into directions, taking TWO directions to assume ONE position.

(See Border Line Cases, Chapter X, for further discussion of this phase of Atlas subluxations.)

Atlas cannot be POSTERIOR. Again we get a contradiction of terms that does and does not mean what it implies. Atlas cannot be subluxated POSTERIOR because of lock against odontoid process. Atlas can be subluxated ANTERIOR because of moving from odontoid process. The ONLY subluxated direction of motion of Atlas IS anterior; then superior or inferior. For this reason we speak of Atlas ANTERIOR-superior and ANTERIOR-inferior. As Atlas anterior arch moves superior it must move ANTERIOR. As Atlas anterior arch moves inferior it must move POSTERIOR on condyles. We now have an Atlas that can only subluxate anterior in relation to Axis yet is posterior in relation to condyles when inferior in relation to condyles. Atlas can only SUBLUXATE anterior in relation to Axis but it can go posterior in relation to its condyles.

If atlas is subluxated ANTERIOR, away from axis, head will follow thru with it TO ANTERIOR. If axis is subluxated posterior away from atlas, head will follow thru with atlas. If atlas is subluxated anterior superior, head will follow thru with it, with exception that head may be MORE superior OR inferior than atlas. If atlas is subluxated anterior (or posterior according to how the term may be used—see previous paragraph for explanation as to this seeming inconsistency in terms) inferior, head will follow thru with it, with exception that head may be MORE superior OR inferior than atlas. Study of con-

dyles of occiput and superior articulations of atlas proves this a ball and socket, or rocker and cradle lock in anterior or posterior possible directions, hence, as atlas subluxates anterior head must follow thru because it cannot be subluxated FROM atlas anterior or posterior but can exaggerate superior or inferior relationship WITH atlas either superior or inferior.

Speaking of "three" directions, we mean each direction being away from what its normal position should be.

Must we NOW introduce the FIFTH element:

1. misalignment with co-respondents above and below
5. WHEREIN THREE DIFFERENT ABNORMAL DIRECTIONS FROM ITS NORMAL POSITION ARE IN PERMANENT MISALIGNMENT.
2. occlusion of a foramen thru which nerves pass
3. pressure upon nerves
4. interference to transmission of mental impulse supply?

INTER-LOCKING OF VERTEBRAE

With a flexible spinal column in hand, let us see what we see while looking.

Let us begin with lumbar vertebrae for there what we are now about to present for the first time will be clearly observable.

(Illustrations 26 to 49 portray this interlocking of vertebrae. Study descriptive matter which accompanies each illustration.)

Take as our sample, THIRD lumbar:

a. It is NOT possible for a third lumbar to be "subluxated" ANTERIOR. Post-zygapophyses of third lumbar, fitting into a cup-like depression on pre-zygapophyses of fourth lumbar, would prevent it. Post-zygapophyses of vertebra above (third lumbar), fitting into pre-zygapophyses of vertebra below (fourth lumbar), fit into a socket which makes it impossible.

b. It is NOT possible for a third lumbar to be "subluxated" POSTERIOR. Pre-zygapophyses of third lumbar, fitting into a cup-like depression on post-zygapophyses of 2nd lumbar would prevent it. Pre-zygapophyses of vertebra below (third lumbar), fitting into post-zygapophyses of vertebra above (second lumbar) fit into a socket which makes it impossible. It would be impossible for third lumbar to subluxate posterior because pre-zygapophyses would lock against post-zygapophyses of 2nd lumbar.

c. It is NOT possible for third lumbar to be "subluxated" INFERIOR. Suppose third lumbar vertebra spinous process were "subluxated" inferior, judging by comparative palpation position of spinous processes of itself with one above and one below. This would automatically raise anterior-superior rim of centrum of third lumbar (vertebra below) and make it contact anterior-inferior rim of centrum of 2nd lumbar (vertebra above). What would anterior-inferior rim of centrum of 2nd lumbar (vertebra above) do to an anterior-superior rim of centrum of third lumbar (vertebra below) if it tried to raise itself up and stay there? Gravity weight would push it down, even if ordinary normal movements didn't.

d. It is NOT possible for a third lumbar to be "subluxated" SUPERIOR. Suppose a third lumbar vertebra spinous process were "subluxated" superior, judging by comparative position of spinous processes of itself with one above and one below. This would automatically raise posterior-superior rim of centrum of third lumbar (vertebra below) and make it contact posterior-inferior rim of centrum of 2nd lumbar (vertebra above) what would this do to a posterior-superior rim of centrum of third lumbar (vertebra below) if it tried to raise itself up and stay there? Gravity weight would push it down, even if ordinary normal movements didn't.

e. It is NOT possible for third lumbar to be "subluxated" CIRCULARLY OR ROTATORIALLY and thus bring one left, or right, articular segment to posterior. Suppose left post-zygapophysis of third lumbar (vertebra below) tried to go posterior, with right post-zygapophysis remaining normal, it could NOT move posterior because pre-zygapophysis of third lumbar would lock against post-zygapophysis of 2nd lumbar (vertebra above) and thus prevent it. At same time, post-zygapophysis of 2nd lumbar (vertebra above) was locking third lumbar so it could not move posterior; right post-zygapophysis of third lumbar would be locked into pre-zygapophysis of fourth lumbar (vertebra below) and again it would be prevented from going anterior on right. Left superior of third would prevent its going posterior; right inferior of third would prevent its going anterior, in which event the vertebra could not move circularly except within the scope of its normal segmental range of motion.

f. The ONLY movement left, within which it could get ANY abnormal range of motion, would be where post-zygapophyses of third lumbar would BOTH move posterior AND pre-zygapophyses of third lumbar would BOTH move anterior; in which event you run directly into "c" and "d", inferior and superior, questions made impossible above.

The question remains, is any ONE normal movement, within normal range of movement, within itself a "SUBLUXATION", and does it produce FIVE ELEMENTS necessary to constitute a subluxation with attendant consequential abnormal permanent effects?

(Illustrations 26 to 49 portray this interlocking of vertebrae. Study descriptive matter which accompanies each illustration.)

Let us take dorsal vertebrae. For, what we are now about to present, for the first time will be now more clearly observable had we not studied lumbar vertebrae.

With spinal column in hand, note spinous processes of approximately 1st to 10th dorsal (which number vary slightly in different people) project obliquely downward and posterior, closely over-lapping superior-posterior surfaces of joined laminae and spinous process of vertebra below. Oftentimes these inter-process surfaces will contain an articulatory surface between inferior of process above and superior of process below. Altho not a true lock, in usual vertebral sense, this does prevent vertebra above from going anterior, hence inferior, practically locking vertebra above from raising or lowering of centra superior or inferior to which that spinous process is attached.

Take as our sample the SIXTH dorsal.

a. It is NOT possible for a sixth dorsal to be "subluxated" ANTERIOR. Post-zygapophyses of 6th dorsal, fitting against a flat surface facing obliquely up and down against pre-zygapophyses of 7th dorsal, would prevent it. Post-zygapophyses of vertebra above (sixth dorsal) fitting against pre-zygapophyses of vertebra below (seventh dorsal) would make it impossible.

b. It is NOT possible for a sixth dorsal to be "subluxated" POSTERIOR. Pre-zygapophyses of sixth dorsal, fitting against two obliquely sloping flat surfaces above and behind it on fifth dorsal, would prevent it. Pre-zygapophyses of vertebra below (sixth dorsal) fitting against post-zygapophyses of vertebra

above (fifth dorsal) fit obliquely against flat surfaces which makes it impossible. It would be impossible for sixth dorsal to sublunate posterior because pre-zygapophyses would lock against post-zygapophyses of fifth dorsal.

c. It is NOT possible for a sixth dorsal to be "subluxated" INFERIOR. Suppose sixth dorsal vertebra spinous process were "subluxated" inferior, judging by comparative position of spinous processes of itself with one above and one below. This would automatically raise anterior-superior rim of centrum of sixth dorsal (vertebra below) and make it contact anterior-inferior rim of centrum of fifth dorsal (vertebra above). What would anterior-inferior rim of centrum of fifth dorsal (vertebra above) do to an anterior-superior rim of centrum of sixth dorsal (vertebra below) if it tried to raise itself up and stay there? Gravity weight would push it down, even if ordinary movements didn't.

d. It is NOT possible for sixth dorsal to be "subluxated" superior. Suppose a sixth dorsal vertebra spinous process was "subluxated" superior, judging by comparative position of spinous processes of itself with one above and one below. This would automatically raise posterior-superior rim of centrum of sixth dorsal (vertebra below) and make it contact posterior-inferior rim of centrum of fifth (vertebra above). What would posterior-inferior rim of centrum of fifth dorsal (vertebra above) do to posterior-superior rim of centrum of sixth dorsal (vertebra below) if it tried to raise itself up and stay there? Gravity weight would push it down, even if ordinary movements didn't.

e. It is NOT possible for a sixth dorsal to be "subluxated" CIRCULARLY OR ROTATORIALLY and thus bring one left or right articular segment to posterior. Suppose left pre-zygapophysis of sixth dorsal (vertebra below) tried to go posterior, with right pre-zygapophysis remaining normal, it could NOT move posterior because post-zygapophysis of sixth dorsal would lock against post-zygapophysis of fifth dorsal (vertebra above) and thus prevent it. At the same time, post-zygapophysis of fifth dorsal (vertebra above) was locking sixth dorsal so it could not move posterior; right post-zygapophysis of sixth dorsal would be locked against pre-zygapophysis of seventh dorsal (vertebra below) and again it would be prevented from going anterior on right. Left superior of sixth dorsal would prevent its going pos-

terior; right inferior of sixth would prevent its going anterior; in which event the vertebra could not move circularly except within the scope of its normal segmental range of motion. Suppose sixth dorsal decided to roam anterior on right. It could not because inferior right post-zygapophysis would lock against superior right pre-zygapophysis of fifth dorsal (vertebra above).

f. The ONLY movement left, within which it could get ANY abnormal range of motion, would be where post-zygapophyses of sixth dorsal would BOTH move posterior AND pre-zygapophyses of sixth dorsal would BOTH move anterior; in which event you run directly into "c" and "d", inferior and superior, questions made impossible above. It MIGHT be possible for superior articulations to move anterior IF posterior articulations moved posterior; and then only IF superior AND inferior co-respondents are willing to permit such. From the very nature of articulations overlapping inferior-posterior on posterior, with superior-anterior on superior, with vertebrae above and below, that even a twist, wrench, kink, or torque would be possible; and then only by and with consent of co-respondents above and below.

The question then remains, is ONE normal movement, within normal range of movement, within itself a "SUBLUXATION" and does it produce FIVE ELEMENTS necessary to constitute a subluxation with its attendant consequential abnormal permanent effects? Is ONE direction a SUBLUXATION? Or is ONE direction a misalignment? Is there any good reason why we cannot have an entire series of one-direction-misalignments up and down entire spinal column; all within normal range of motion; many of which MIGHT become chronic in one-direction-misalignments; all compensatory and adaptative to A ONE MAJOR SUBLUXATION above? Why "adjust" compensatory misalignments when they are NOT SUBLUXATIONS?

(Illustrations 26 to 49 portray this interlocking of vertebrae. Study descriptive matter which accompanies each illustration.)

Study cervical vertebrae with their interarticulating and interlocking facets minus those unusual vertebrae—occiput, atlas and axis. Conditions applicable for lumbar and dorsal vertebrae hold good with all other cervical vertebrae EXCEPT FOR PECULIAR ARTICULATING RELATIONSHIPS BETWEEN AXIS, ATLAS AND OCCIPUT. Here we find ALL vertebral rules set at

naught; otherwise applicable, violated by a set of conditions FOR WHICH NO OTHER RULES APPLY; and for the first time A NEW SET OF RULES HAS BEEN SEARCHED AND RESEARCHED, found, and displayed in this book. Axis, atlas, and occiput demand a set of rules for themselves.

There are only TWO articulations between occiput and atlas. THREE exist between atlas and axis. Six exist between axis and 3rd cervical. And not less than six between ALL vertebrae below. The TWO occipito-atlas articulations are approximately level and horizontal possessing three directions of motion, viz: anterior or posterior, lateral left or right, and superior or inferior. Between occiput and atlas is THE ONLY place in vertebral column (of movable vertebrae) where articulations are TWO in number. Altho three exist between atlas and axis, two only exist so far as lateral slippage is concerned and only one so far as anterior or posterior is concerned; which prevents posterior movement of atlas and by inverse direction, prevents axis moving anterior. No wonder atlas is a weak and vulnerable unit in inter-vertebral-interlocking articulatory chain.

Every articulation is a possible motion. The more articulations the more limited the motion of each. The fewer in number the greater motion they possess. A vertebra of 6 articulations is limited to the sum total of 6 limited motions. A vertebra of 2 articulations is unlimited to the sum total of only 2 articulations.

a. INFERIOR of axis articulations apply with ALMOST equal emphasis of other vertebrae, but SUPERIOR of axis does not. INFERIOR of axis is comparatively like vertebrae below. SUPERIOR of axis is in another world by itself, not duplicated. I suggest now, while the matter is fresh, that you make a review study of lateral spinographs and note frequency of inferior (only) distortion, kink, twist, wrench, or torque that exists BETWEEN axis and 3rd cervical. It happens frequently and therefore demands investigation such as we have now given it. More of this will be observed under spinographic plates wherein plane lines have been drawn and demonstrated.

b. ALL cervical articulations, beginning with INFERIOR of axis and on down to and including transitional seventh cervical

have articulations, both pre and post-zygapophyses, that are obliquely flat; all sliding to rear and inferior. This makes possible compression on posterior that we so often find in cervical areas with posterior and inferior (PI) torque subluxations of axis. It is a multiplication of accumulation of compression of normal limited action of each individual vertebra within its normal range.

c. All cervical vertebrae, beginning with inferior surface of axis, have some form of interlocking on some of their articulation surfaces. Inferior surface of centrum of axis, on anterior inferior rim, presents an extended convex lip projecting downward, overlapping and fitting into a concave indentation on superior anterior rim of 3rd cervical. The same is true of all cervical vertebrae. This prevents axis, as well as other cervical vertebrae, from slipping posterior on 3rd or other cervical vertebrae below, and acts as a series of locks between inferior of superior vertebra and superior of inferior vertebra. This anterior lock, plus the posterior lock between zygapophyses, prevents cervical vertebra from subluxating anterior (from posterior) or posterior (from anterior). This antero-posterior lock which prevents posterior movement of axis upon 3rd cervical, does not prevent axis and other cervical vertebrae from raising superior on anterior thus permitting movement inferior on posterior, overlapping spinous process of 3rd cervical and other cervical vertebrae, making it possible to permit separation between axis and 3rd cervical on anterior, a condition frequently found in posterior-inferior subluxations of axes as revealed on lateral spinographic views.

The more superior we go, in the spinal column, the less this gravity weight becomes; and by inverse ratio, the more motion increases; therefore we reduce the value of gravity in correcting the superiority or inferiority of superior or inferior distortions of the centra, on the reverse increase their possibility by increased motion.

d. A lateral view of cervical vertebrae between inferior surface of axis down to and usually including 6th and 7th, and sometimes including between 7th cervical and 1st dorsal, a marked anterior-posterior lock between the zygapophyses (post and pre) locking against the rudimentary lateral posterior tubercle. Should the pre-zygapophysis of vertebra below desire to move

superior and anterior, it would fit into a marked V-shaped lock as stated.

e. Axis can become subluxated inferior because there is nothing on its superior surface to lock it and prevent it from moving inferior as is true of all other cervical, dorsal, and lumbar vertebrae. Post-zygapophyses of axis lies upon a sliding surface which makes it easy to move to posterior with nothing on its superior to prevent it. If axis decided, with its spinous process, to move to left or right, there still is nothing to prevent it on superior surface of axis; and post-zygapophyses, both being on a sloping surface downward and backward would make it easy to rotate to left or right on one side or other.

f. Superior axis articulations are comparatively flat, sloping slightly backward, upon which rests atlas that rotates, glides upon and around on them, at a place where greatest freedom of motion exists of any place in spinal column.

g. Superior axis has an odontoid which is singularly a distinctive feature all its own, not in common with ANY OTHER vertebra above or below, around which atlas pivots. Atlas is a freely moveable vertebra merely sitting down UPON an axis having comparatively flat surfaces for it to slide around, subject to complete rotation around odontoid; subject to being SUBLUXATED superiorly or inferiorly, on one side or other; anteriorly as a totality; anterior arch being subject to being superior or inferior upon odontoid process of axis, and nothing to prevent it; subject to being kinked, twisted, wrenched, or torqued in various, many, and multitudinous complexed THREE-DIRECTION situations with nothing to interfere or prevent.

h. The large, enlarged bulbous structure superior to atlas, called the head, rests with approximately rocker surfaces on its inferior upon approximately cradle surfaces on superior of atlas; in which one surface rocks back and forth upon the other, oftentimes to extremes, with little to prevent atlas going in various, many, and multitudinous complexed THREE-DIRECTION situations.

i. With large head above acting as a fulcrum; with vertebrae below axis acting as an anchor; with the little thin atlas wedged in between, subject to violations of greatest motion of

anywhere in spinal column, both normal and abnormal; is it any wonder that axis and atlas are torqued badly? Study lateral views of atlas subluxations and see where it is frequently torqued-subluxated, as illustrated in this book. Study the oftentimes seemingly impossible positions of head as compensatory and adaptative to torqued-subluxations of atlas, as illustrated in lateral spinographs of atlas subluxations in this book. If such **THREE-DIRECTION TORQUED SUBLUXATIONS CAN EXIST, IN THIS PECULIAR REGION**, what is the peculiar advantageous and strategical position held by odontoid lying between atlas and axis, running its dangerous tooth-like head up into neural canal?

If a vertebra is off normal position in one direction for an hour, and then returns to normal position, is that a subluxation and could it produce a dis-ease? That it would not be at ease, for an hour, is obvious; but would this be construed as a disease in the common acceptation of the term? Would the not-at-ease condition of one mis-direction, for one hour, create a condition sufficiently gross for the case to feel, observe, and know?

No vertebra IS subluxated UNLESS it is off normal position **THREE** directions and **REMAINS** permanently so. Could a vertebra that is off normal position **THREE** directions and **REMAINS** permanently so, create disease in the common acceptation of the term? Would the disease condition, of three off normal directions, permanently so, create a condition sufficiently gross for the case to feel, observe, and know? That depends upon what interpretation is placed upon "permanent."

Dis-ease, as an effect, is an accumulation condition, growing over hours, days, weeks, months, or years. To **GROW** an effect, **CAUSE MUST BE PERMANENT** to permit time element to enter so it **CAN** grow. To have a vertebra out of alignment; one, two, or even three directions (if such were possible) for a few minutes, would not be a **PERMANENT** condition. No vertebra **IS SUBLUXATED UNLESS** it is off normal position, **THREE** directions and **REMAINS** such.

We do have temporary misalignments of one direction and they do correct themselves internally. This occasionally may occur in lower cervical, dorsal, and lumbar vertebrae.

No one or two abnormal movements of vertebrae can "lock" themselves into a permanent abnormal position. THREE directions of abnormal position "lock" themselves out of position. It is this "locking" that makes a three direction misalignment into a three direction SUBLUXATION. It is "locking" which makes a TEMPORARY condition into a PERMANENT one. Permanency is what MAKES IT A SUBLUXATION. THREE direction subluxations are torqued into a LOCKED permanent position wherein nothing INTERNAL can "unlock" them. It takes an EXTERNAL force to "unlock" the three directioned-torqued subluxation.

The ONLY place in spinal column where we can have a THREE direction, torqued, "locked" permanent SUBLUXATION is in occipital, atlas, and axis combination relationship articulations. No other place in spinal column is it possible to have a THREE direction, torqued, "locked" PERMANENT misalignment.

If all vertebrae below axis cannot be subluxated, because they are osseously locked, then what did you do when you applied one-half a concussion of forces, heard them crack and pop, and THOT they moved? You applied one-half a concussion of forces; you jarred a vertebra within its locking extents; you neither moved it out of subluxation into apposition, nor moved it from apposition into a subluxation. You introduced one-half a concussion of forces which TRAVELED to where vertebrae COULD BE and WERE subluxated, at which place it either did good by REducation or bad by greater PROduction. You thot you were direct in application, at place thot to be correct, when in reality you were trying to do a good remote control job at wrong place.

As Chiropractic proof of "adjustment" of a "subluxation" below axis, have you heard them crack, pop, or snap? Wasn't that proof? If it was NOT "subluxated" how could you "adjust," assuming that cracking, popping, or snapping WAS proof of "adjustment"?

Back in the '90s, medical men denied possibility of vertebral subluxation. To prove his contention, he would crack, pop, or snap finger joints, jerking one side of joint from the other, raising the question: "Was that a 'subluxated joint' and did I 'ad-

just' it by jerking it and hearing it crack, pop, or snap?" Any articulatory joint in the body can be made to normally crack, pop, or snap by normally separating by jerking one side of an articulation from its opposite. Professional dislocationists do it regularly and use cracking, popping, or snapping sound to convince the unsophisticated. The PSC X-ray laboratories have radiographed many of these "dislocations" only to have the X-ray prove that such did NOT exist even tho it had every external appearance of being such in fact.

Any "adjustment" given on anything LESS than a three-direction misalignment is NOT an adjustment because it IS NOT a subluxation. Any "adjustment" given on any misalignment that is NOT torqued-"locked" is not on a subluxation. Any movement directed upon anything short of a three-direction misalignment is but treatment upon effect. Any "adjustment" given upon a three-direction locked misapposition of articulations, at occiput, atlas, or axis, WHEREIN ONLY ONE OR TWO DIRECTIONS are moved or jarred, is NOT an ADJUSTMENT because the THREE directions are not "unlocked." AN ADJUSTMENT IS THAT UNLOCKING PROCESS UPON ALL THREE LOCKED DIRECTIONS OF A TORQUED SUBLUXATION, WHEREVER SUCH CAN OCCUR. To "adjust" upon a locked or torqued SUBLUXATION, in one or two directions, is to "move" or "jar" the locked subluxation, only to have them return to their locked condition once more.

If, in the process of wisdom and time, Innate Intelligence saw fit to build necessary locks upon vertebrae to keep them from becoming subluxated or dislocated, why has the same Innate Intelligence overlooked, forgotten, or left unguarded three unlocked directions of movements between occiput, atlas, and axis? To this question, we finite beings cannot answer for the Infinite. Man is still in the process; he has not yet arrived. What the "process" was, is, or will be, we do not know. Man may still be passing thru the "process" of evolution of change from simian and moving about by his long forearms and prehensile tail. Or he may still be passing thru the "process" of evolution of change from quadruped to biped and he hasn't learned to change front legs to arms with necessary adaptation in his cervical spine.

A Yale lock may have three tumblers. Many keys might "unlock" ONE or even TWO tumblers; but the door is never unlocked UNTIL ALL THREE TUMBLERS ARE IN APPOSITION TO EACH OTHER. Then the lock WILL unlock easily, and remain so.

Lumbar, dorsal, and lower cervical vertebrae, and up to inferior of axis vertebra, are normally locked in their normal articulations with each other to prevent any one from being normally unlocked in three directions simultaneously from each other. Concussion of forces could not abnormally unlock one vertebra from its normally locked articulations with its co-respondents so it could be abnormally forced into a three-direction locked subluxation. This condition does NOT apply to axis, atlas, and occiput. Neither is normally locked in normal articulations with each other; there is no articulating lock between occiput and atlas, atlas and axis, to prevent either of them being abnormally unlocked in three directions simultaneously from their articulations. Either of them could be unlocked so it could be abnormally forced into a locked subluxation. Either atlas or axis can be abnormally locked in an abnormal unlocked subluxation position.

Illustration No. 26.

Every vertebra, beginning with INFERIOR of axis down, is locked in EVERY direction—posterior, anterior, right, left, superior, inferior, and ANY and ALL combinations thereof.

Atlas, axis, and 3rd cervical vertebrae. Lateral view. Separated.

Inferior surface of "A" articulates with superior surface of "B." Note absence of any osseous articular lock to keep "A" from slipping on or off "B" except for odontoid process which does not prevent rotation or wedge side-slipping of "A" upon "B." Illustration No. 30 is a close-up of atlas and axis, articulating. Note absence of any lock between "A" and "B".

The oblique articulating surface of "C", facing anterior and inferior, fits into "D", facing posterior and superior, and locks against anterior movement of "C", or posterior movement of "D". In addition to this lock between axis and 3rd cervical, note

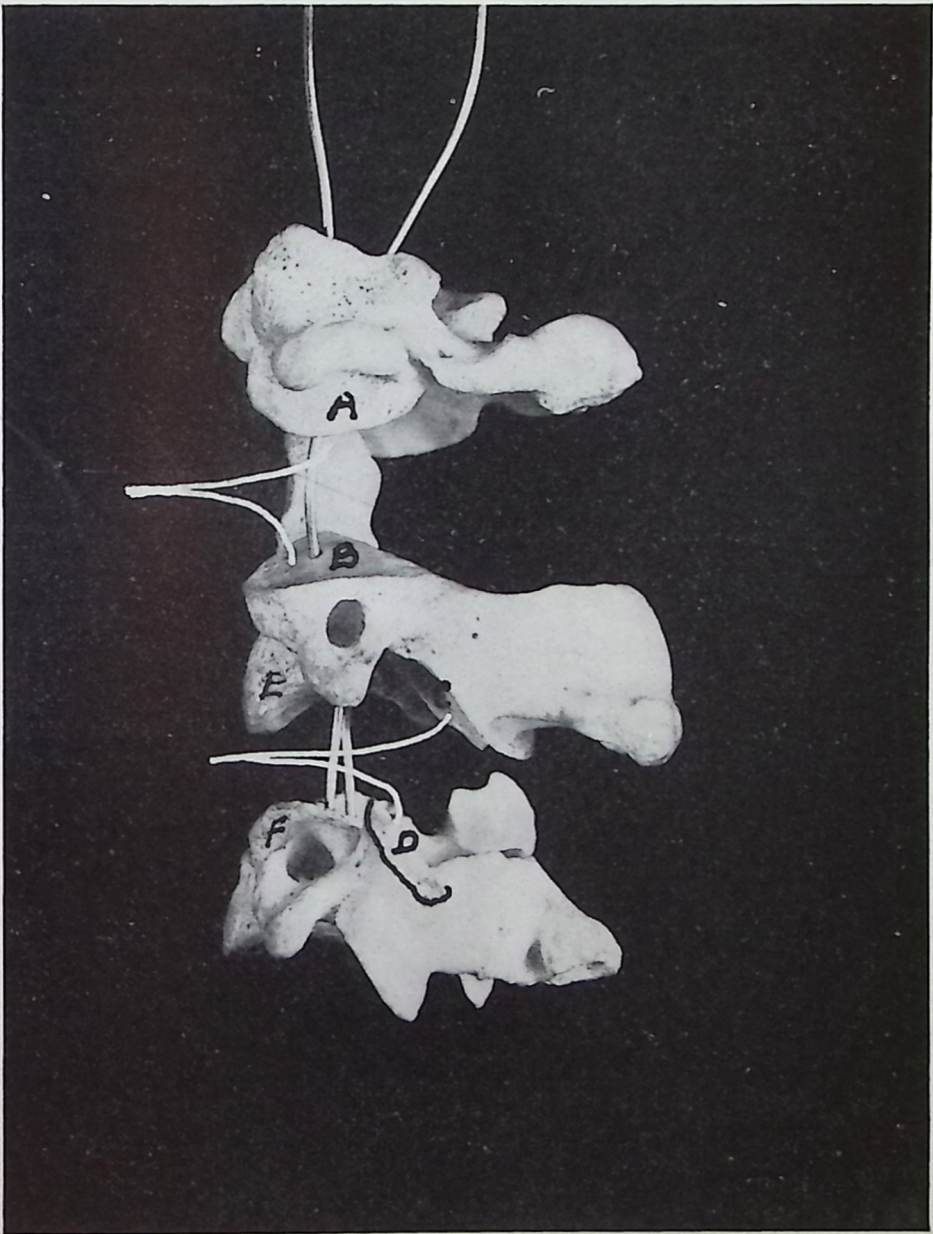


Illustration No. 26

overhanging lip "E" that sets down into "F" and locks posterior movement of axis. Note same overhanging lip "I" as it fits into "J" in Illustration No. 28 as well as "C" on Illustration No. 30.

Illustration No. 27.

Atlas, axis, and 3rd cervical. Posterior view. Separated.

"A" articulates with "B", "C" with "D", "E" with "F", and "G" with "H".

Study of "A-B" and "C-D" shows no form of locking structure to prevent wedge-side-slipping. Study "A-B" and "C-D" on Illustration No. 28, posterior view, and again note absence to prevent wedge-side-slipping. Note same fact, enlarged, in Illustration No. 29 between "C-D" and "E-F", as well as same fact in lateral view of Illustration No. 29 between "A-B".

"F-H" show slipping character of articulations with lock anterior movement of "E-G", also which lock posterior movement of "F-H".

Illustration No. 28.

Atlas, axis, and 3rd cervical. Anterior view. Separated.

"A" articulates with "B", "C" with "D", "E" with "F", "G" with "H", "I" with "J".

"E-G" articulate with "F-H" and lock anterior movement. "I" locks into "J" and locks posterior movement. Axis is locked both ways.

Careful study of Axis and 3rd cervical in Illustration No. 26 between "C-D" and "E-F" as well as in Illustration No. 28 of "I-J" in Illustration No. 30 shows no lock which prevents inferior movement of spinous process of axis overriding against spinous of 3rd, thereby separating "E-F" in Illustration No. 26 and "I-J" in Illustration No. 28. Illustration No. 30 with "C-D" shows how "D" could squeeze inferior on posterior, and "C" could raise superior on anterior. There is no lock to prevent this.

There is considerable loose-play motion between odontoid and anterior arch surface. Illustrations Nos. 27-28 show nothing to lock atlas in wedge-side-slipping either to left or right between "A-B" and "C-D" on either view. Comparatively flat surfaces make this easy.

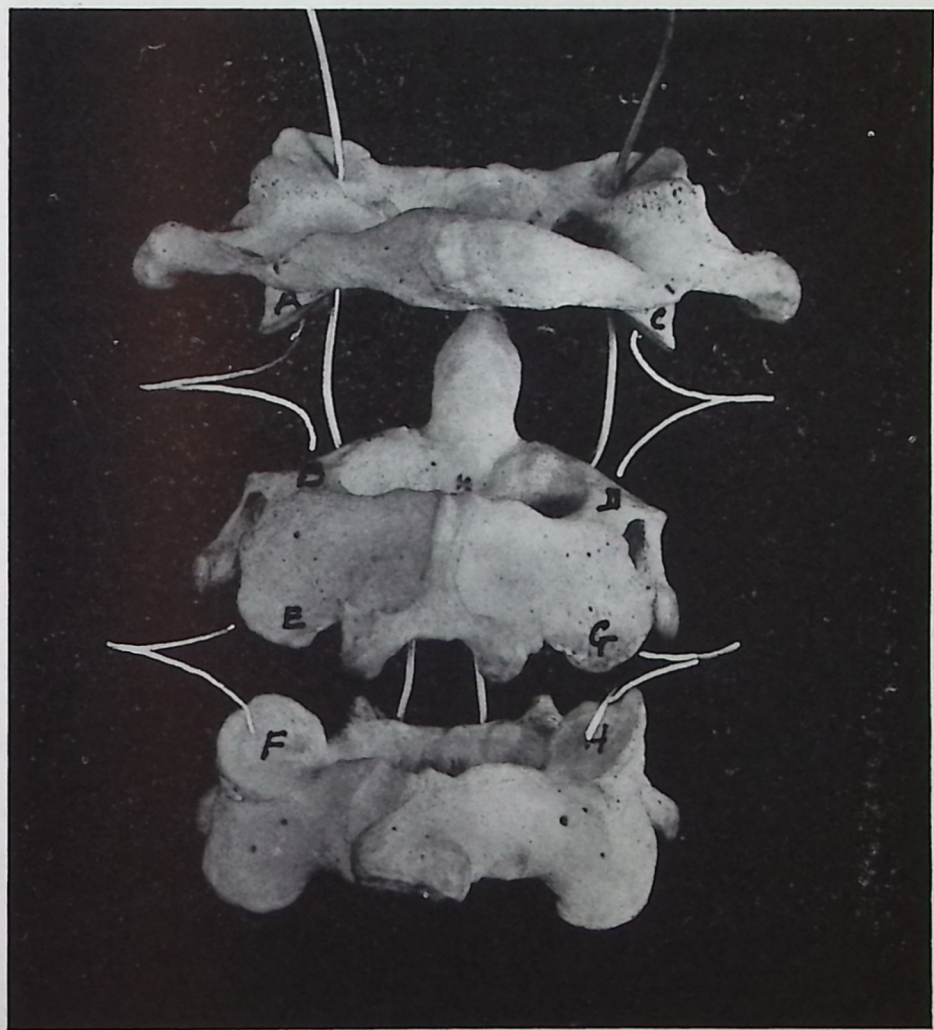


Illustration No. 27

Illustration No. 29.

Atlas and axis. Posterior view. Articulated.

"A-B" superior articulations for condyles of occiput. They are convex and slope inward and upward, permitting a rocking forward or backward of head. Note superior portion of atlas in Illustration No. 30.

Illustration No. 30.

Atlas and axis. Lateral view. Articulated.

Absence of any lock between "A-B". Easy matter to slip off articulation.

Illustration No. 31.

4th, 5th, and 6th cervical vertebrae. Lateral view. Separated.

"A-B", "C-D" articulate. When "A" articulates against "B", "A" is locked from going anterior. When "B" articulates against "A", "B" is locked from going posterior. When "C" articulates against "D", "C" is locked from going anterior. When "D" articulates against "C", "D" is locked from going posterior.

"E" is anterior-inferior convex lip that overhangs and fits into concave concavity "F" on anterior-superior surface of rim of vertebra below and locks it from going posterior. There is nothing in this lock which prevents anterior raising superior, or posterior lowering inferior, as is frequently found when spinous processes are squeezed together on posterior.

Notice this "A-B" and "C-D" lock in Illustration No. 35. "A" cannot move anterior because of "B". "B" cannot move posterior because of "A". Neither can "C" move anterior because of "D". "D" cannot move posterior because of "C".

"G" is same to vertebra below, that "E" is to vertebra above, and locks itself into concavity "H" of vertebra below, preventing it from going posterior. There is nothing on this lock which prevents anterior from raising superior or posterior lowering inferior, as is frequently found when spinous processes are squeezed together on posterior.

This is further illustrated by studying "E-F" and "G-H" in Illustration No. 35. Also note "A-B" and "C-D" in Illustration No. 36.

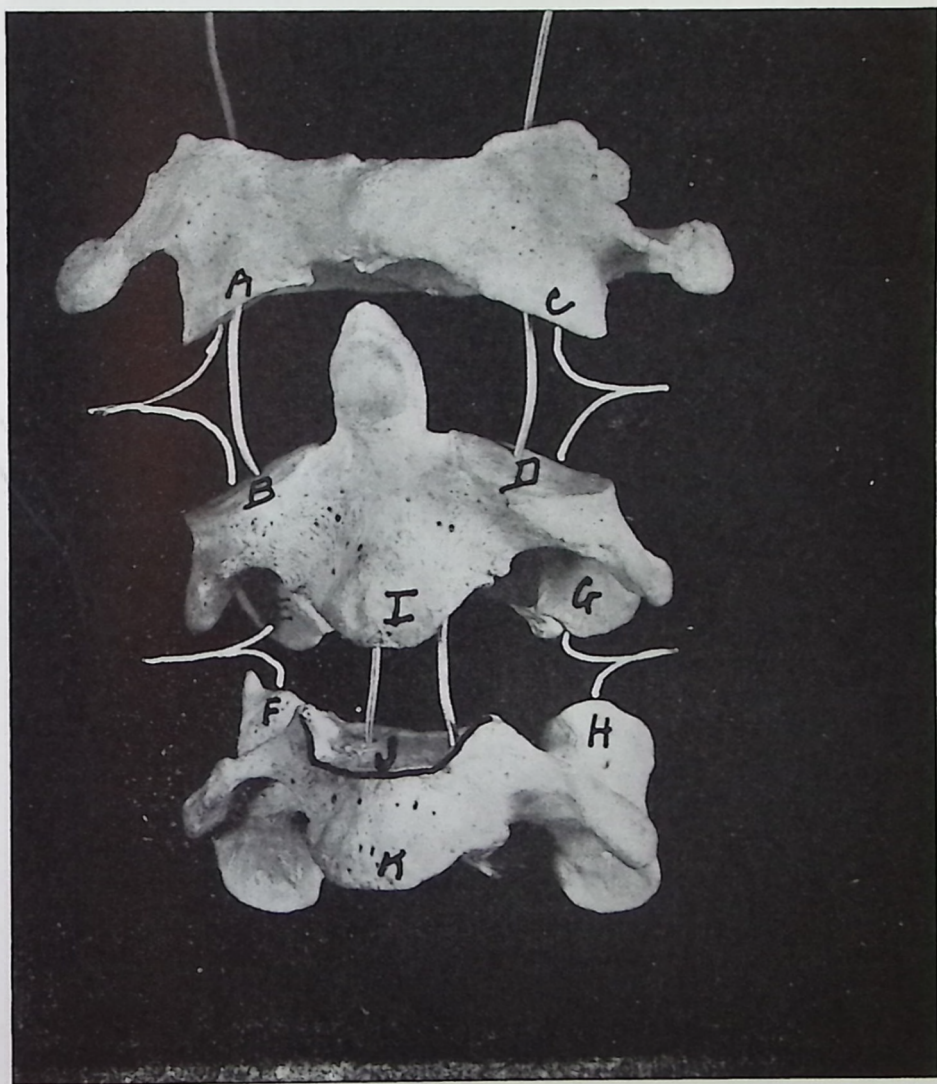


Illustration No. 28

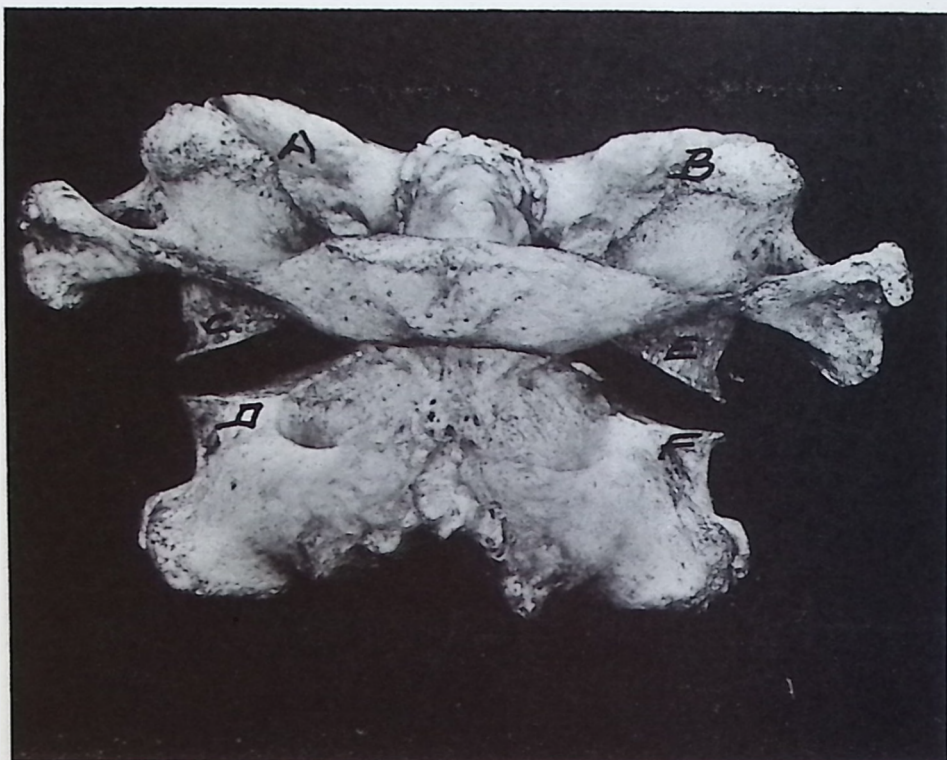


Illustration No. 29

Illustration No. 32.

4th, 5th, and 6th cervical vertebrae. Posterior view. Separated.

In this view you cannot see facets of "A", "C", "E", and "G". Facets of "B", "D", "F", and "G" are observable. First four slope inferior and anterior. Latter four slope posterior and superior. Overlapping of "A" and "C" being inferior and anterior is what locks superior vertebra from moving anterior. Underlapping of "B" and "D" is what locks them from moving posterior. Same would be true of articulations of two lower vertebrae.

This fact is more clearly illustrated with "A-B" and "C-D" in Illustration No. 35.

Illustration No. 33.

4th, 5th, and 6th cervical vertebrae. Anterior view. Separated.

This view clearly portrays convex overlapping. Lip of "I" as it fits down and into concave depression "J" on anterior rims between 4th and 5th cervical vertebrae. Same is true between 5th and 6th cervical vertebrae between "K" and "L". This locks superior vertebra from moving posterior.

Illustration No. 34.

4th, 5th, and 6th cervical vertebrae. Posterior views. Articulated.

"A-B", "C-D", "E-F", "G-H" overlap each other. Superior "A-C-E-G" cannot move anterior because they are locked against "B-D-F-H". "B-D-F-H" cannot move posterior because they are locked against "A-C-E-G". In addition to these posterior locks,



Illustration No. 30

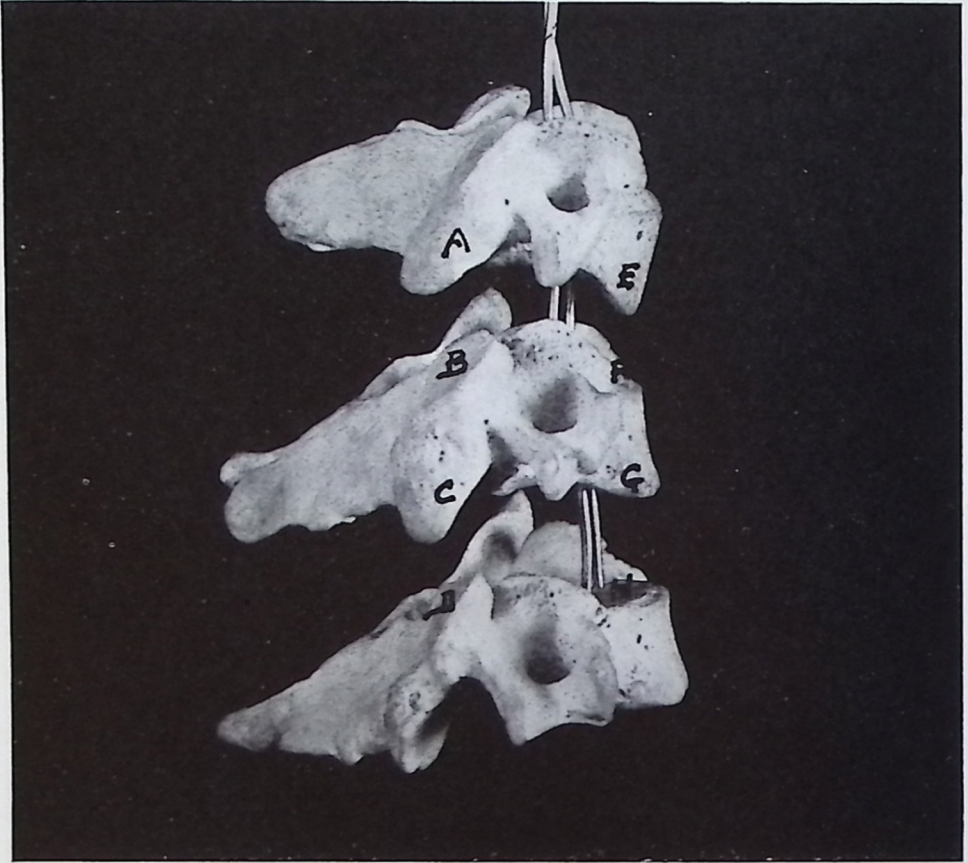


Illustration No. 31

they are locked on anterior by overlapping lips. See "I-J" and "K-L" in Illustration No. 33.

Illustration No. 35.

4th, 5th, and 6th cervical vertebrae. Lateral view. Articulated.

"A" locks against "B" and cannot move anterior. "B" locks against "A" and cannot move posterior. "C" locks against "D" and cannot move anterior. "D" locks against "C" and cannot move posterior. "E" locks into "F" and cannot move posterior. "G" locks into "H" and cannot move posterior.

IF "B" tried to move anterior, it would meet additional lock of lateral tubercle "I". If "D" tried to move anterior, it would meet additional lock of lateral tubercle "J".

There is no lock which prevents spinous processes from squeezing together on posterior and separating centra superior to each other on anterior.

Illustration No. 36.

4th, 5th, and 6th cervical vertebrae. Anterior view. Articulated.

Overlapping nature of anterior-inferior convex lip "A" on centrum is clearly observable here. It fits into a concave depression made to fit "B". Same is true between "C" and "D". These gradually fade out until they are gone at lower level of 7th cervical. Other character of locks supplant them there.

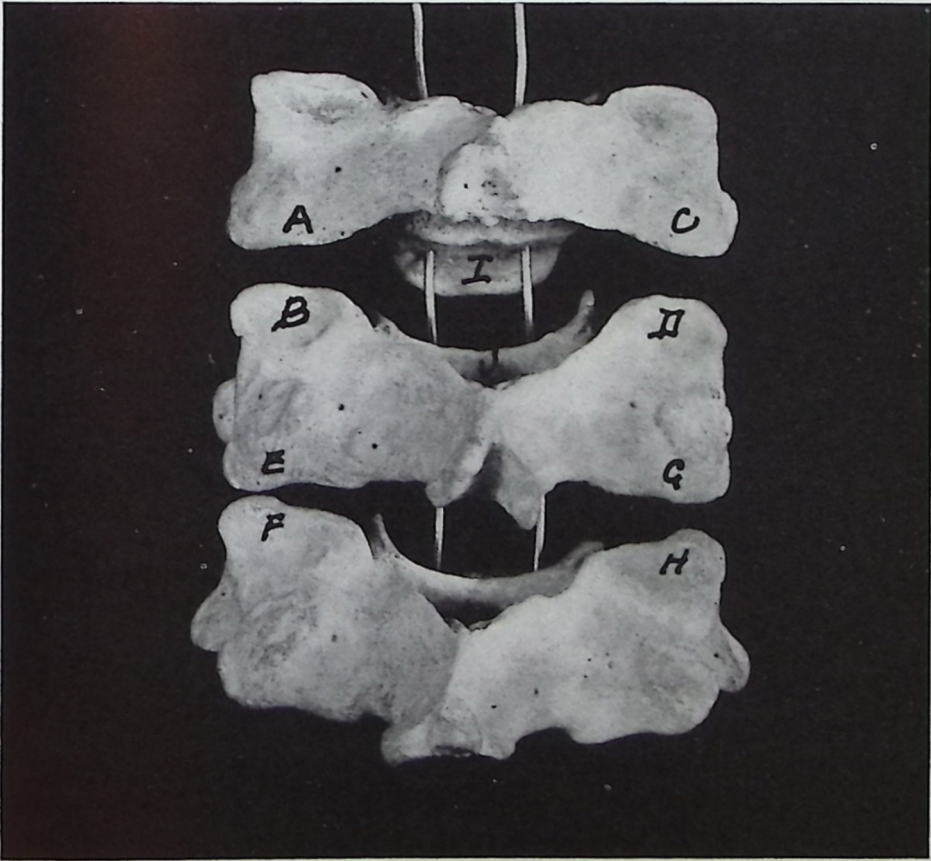


Illustration No. 32

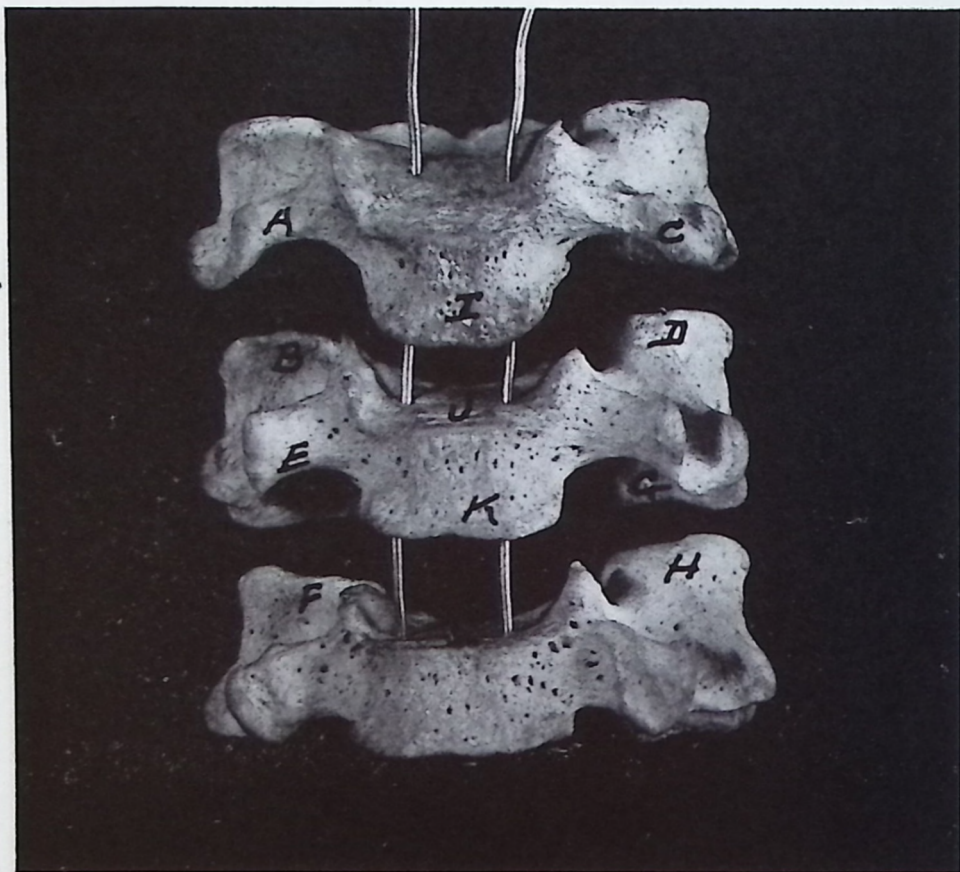


Illustration No. 33

Illustration No. 37.

Oblique slanting direction of post-zygapophyses of cervical vertebra above, upon pre-zygapophyses of cervical vertebra below (which prevent anterior or posterior movement of cervical vertebrae) plus over-hanging convex lip of centrum of vertebra above into concave depression of anterior of centrum of cervical vertebra below (which prevent posterior movement of either vertebra upon each other), does not prevent any or all cervical vertebrae being compressed or squeezed together in over-lapping spinous processes, as illustrated. Subluxations of atlas or axis necessitate adaptations of head above, as well as cervical vertebrae below, one of which is compression of spinous processes

with attendant separation of centra on anterior. Many spino-graphs portray this. Study LATERAL views and note varying degrees of this normal adaptation to lateral, superior, inferior, or posterior subluxations of atlas or axis.

Cervical vertebrae present no locks to prevent posterior compression. This is a posterior adaptation to anterior-superior or anterior-inferior atlas subluxations, and is to posterior inferior axis subluxations what lateral cervical curves (seen in A-P views) are to lateral atlas or axis subluxations superior to those curves.

Illustration No. 38.

5th, 6th, and 7th dorsal vertebrae. Lateral view. Separated.

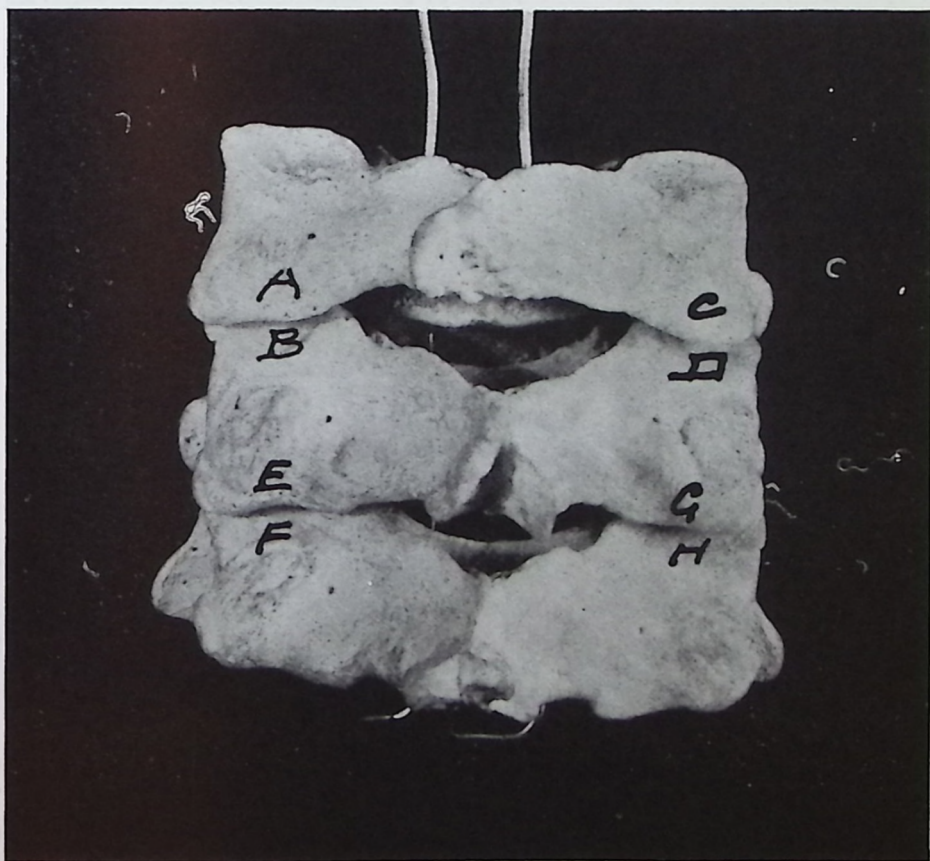


Illustration No. 34

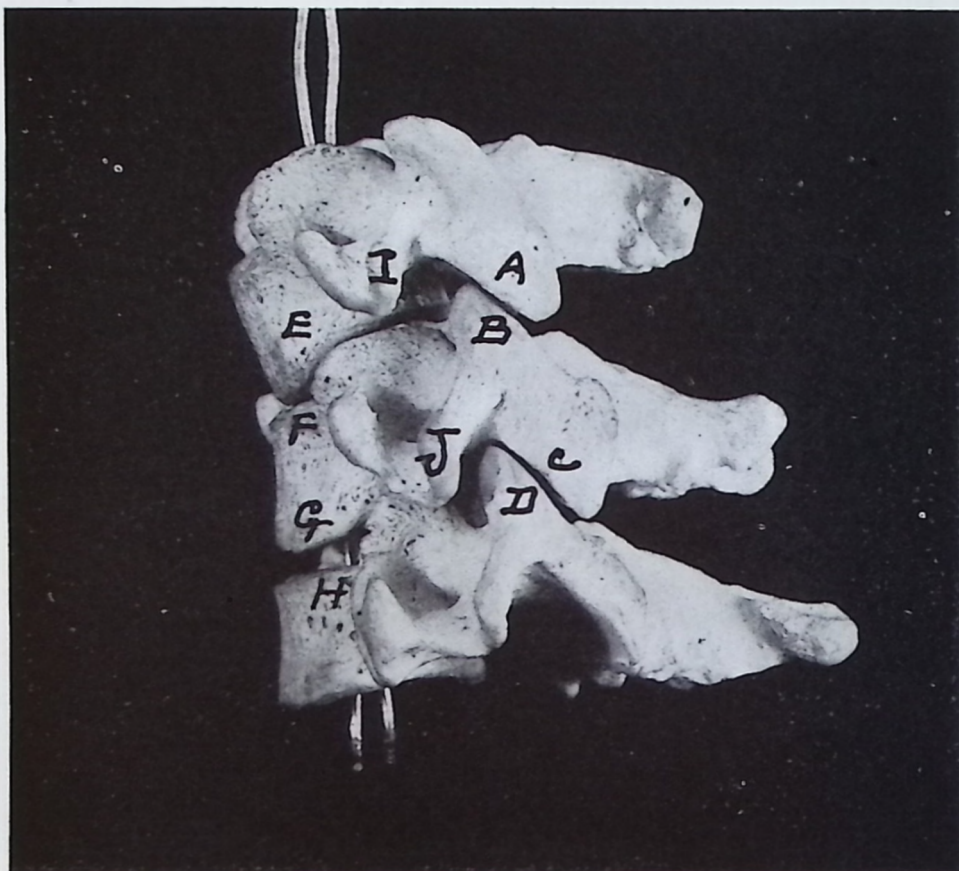


Illustration No. 35

"A-B" articulate together. So do "C-D". "A" faces almost anterior, slightly obliquely inferior. "B" faces almost posterior, slightly obliquely superior. Same is true of "C-D". "A" and "C" are locked by "B" and "D" which prevents their moving anterior. "B" and "D" are locked by "A" and "C" which prevents their moving posterior.

Illustration No. 39.

5th, 6th, and 7th dorsal vertebrae. Posterior view. Separated.

"A-B", "C-D", "E-G", and "F-H" articulate with each other on their respective facets. Same locking condition exists here as mentioned for Illustration No. 38. Suppose middle vertebra (6th dorsal) decided to try to move to right. What would hap-

pen? "B" would lock against "A" and "F" would lock against "H". Suppose middle vertebra (6th dorsal) decided to try to move to left. What would happen? "D" would lock against "C" and "E" would lock against "G".

6th dorsal cannot move posterior, anterior, left or right. It is locked in all directions by articulations.

Illustration No. 40.

5th, 6th, and 7th dorsal vertebrae. Posterior view. Articulated.

Suppose these vertebrae were in a human body. Suppose superior or center vertebra tried to move anterior. "A-C" would lock against "B-D". Suppose center or lower vertebra tried to

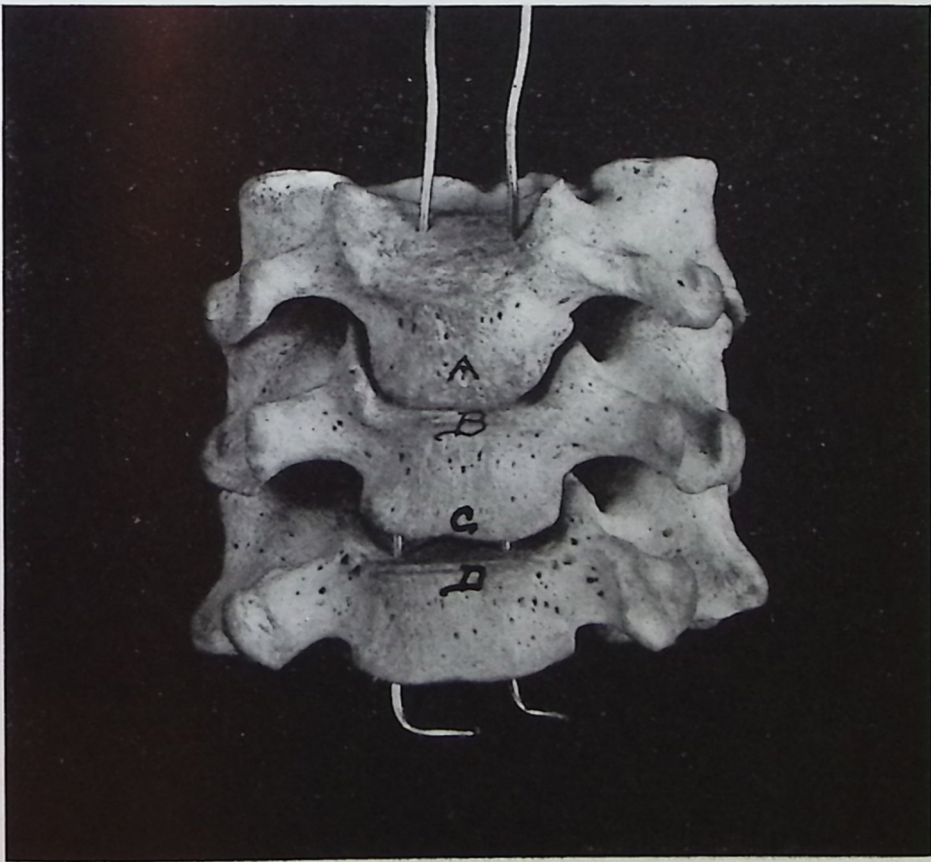


Illustration No. 36

move posterior. "B-D" would lock against "A-C" and "F-H" would lock against "E-G".

Suppose center vertebra tried to move right. "B" would lock against "A" and "G" would lock against "H". Suppose center vertebra tried to move left. "D" would lock against "C" and "F" would lock against "E".

Illustration No. 41.

5th, 6th, and 7th dorsal vertebrae. Lateral view. Articulated.

Study center vertebra. Suppose it decided to move posterior. "B" locks against "A". Suppose superior vertebra decided to move anterior. "A" locks against "B". Suppose center vertebra decided to move anterior. "C" locks against "D". Suppose inferior vertebra decided to move posterior. Then "D" locks against "C".

Illustration No. 42.

5th, 6th, and 7th dorsal vertebrae. Lateral view. Articulated. Anterior of two lower vertebrae crowding.

In our text we have suggested further possibility of one vertebra trying to become inferior by one spinous process crowding another, by comparisons of itself with ones above and below. Here we have attempted to illustrate that condition. Anterior superior rim of lower vertebra is crowding anterior inferior rim of centrum of vertebra above. In this event, gravity weight of body mass above, induced further by natural movement, would force them into alignment by pushing it downward.

Illustration No. 43.

5th, 6th, and 7th dorsal vertebrae. Lateral view. Articulated. Anterior of two superior vertebrae crowding.

In our text we have suggested further possibility of one vertebra trying to become superior by one spinous process crowding another, by comparisons of itself with ones above and below. Here we have attempted to illustrate that condition, altho it was difficult even with vertebrae loose and strung on cat-gut. The zygapophyses making it so. Anterior inferior rim of superior vertebra is crowding anterior superior rim of centrum of vertebra below. In this event gravity weight of body mass above, induced further by natural movement, would force them into alignment by pushing it downward.



Illustration No. 37

Illustration No. 44.

2nd, 3rd, and 4th lumbar vertebrae. Lateral view. Separated.

Articulations in lumbar change from those in cervical and dorsal. In cervical and dorsal they are more or less flat surfaces, so positioned that they lock both anterior and posterior movement. In lumbar vertebrae they are a rounded-out concave cup-like depression on superior vertebra and a rounded-out convex cup-like elevation of superior on inferior vertebra. They fit from above downward, inferior fitting posterior of superior. (See Illustration No. 45 for better picture of this description.)

In this illustration "A" fits into "B", as "C" fits into "D". "A" cannot move forward as it is locked by "B". Same is true of "C" with "D". "B" cannot move posterior as it is locked with "A". Same is true of "D" with "C".

Illustration No. 45.

2nd, 3rd, and 4th lumbar vertebrae. Posterior view. Separated.

Note how "A" fits into "B" as "C" fits into "D"; as well as "E" into "F" and "G" into "H". "B-D" have a curved cut-out depression which locks on sides as well as anterior, and prevents "A-C" moving anterior. "A-C" fit into this curved cut-out depression of "B-D" on sides as well as anterior, and prevent "B-D" moving posterior. Should superior portion of vertebra "B-D" decide to move anterior, it would be prevented by lock on the inferior "E-G". Reverse would be true if inferior portion of vertebra "E-G" decided to move posterior; it would be prevented by lock on superior "B-D".

Suppose vertebra tried to move right, then "B" would lock against "A", and "G" would lock against "H". If vertebra tried to move left, then "D" would lock against "C" and "E" would lock against "F".

A lumbar vertebra cannot move posterior or anterior, right or left, except within normal confines of its osseous articulatory locks which prevent its going further.

Illustration No. 46.

2nd, 3rd, and 4th lumbar vertebrae. Posterior view. Articulated.

"A-B" and "C-D" are in articulation. "A-C" would prevent

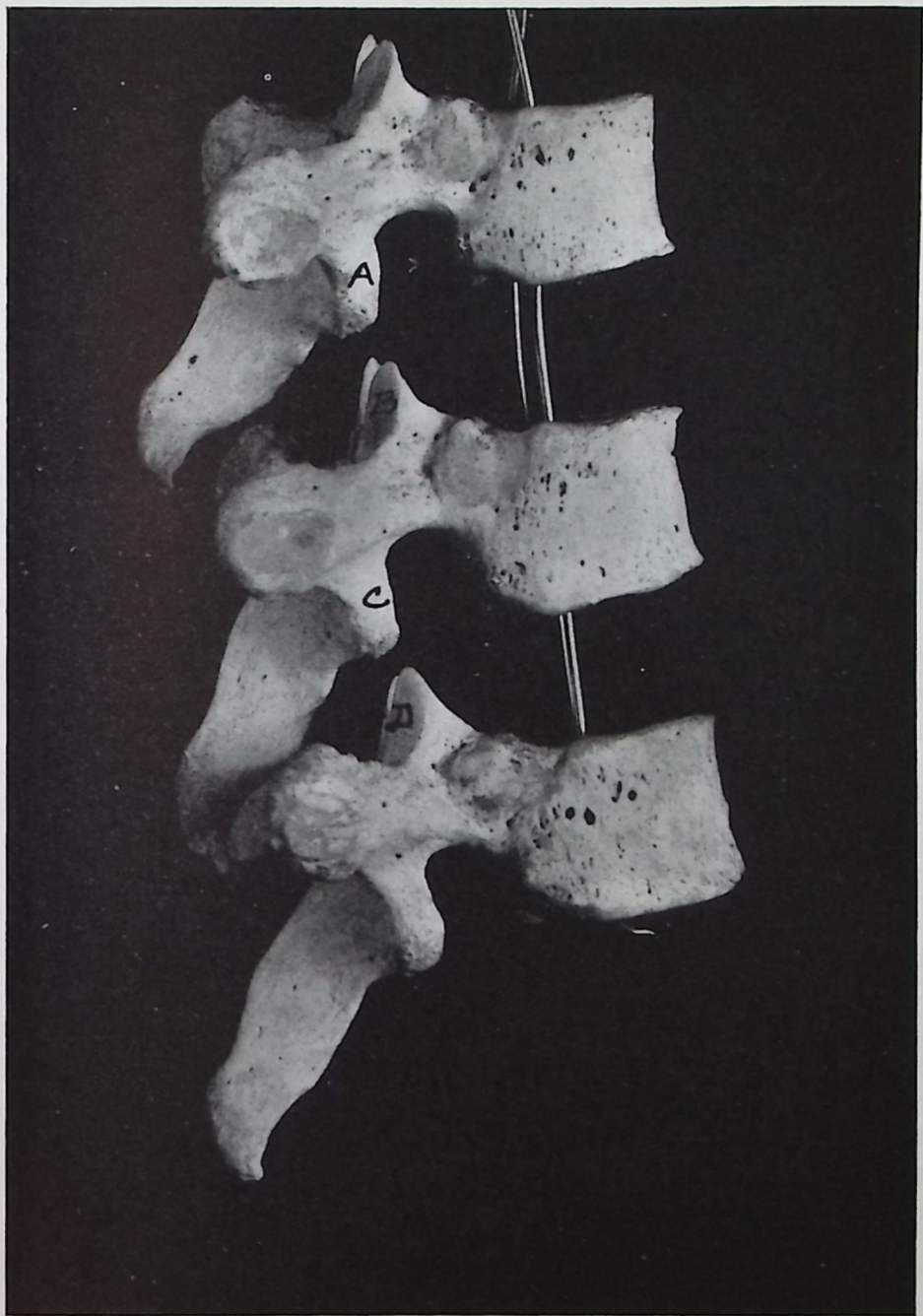


Illustration No. 38

"B-D" going posterior. "B-D" would prevent "A-C" going anterior. Same is true of "E-G" and "F-H".

Suppose middle vertebra decided to try to go right. "B" locks against "A" and "G" locks against "H". Suppose it decided to try to go left. "D" locks against "C" and "E" locks against "F".

Illustration No. 47.

2nd, 3rd, and 4th lumbar vertebrae. Lateral view. Articulated.

"A-B" articulate within their depressional concavity. "A" cannot move anterior; "B" cannot move posterior. Same is true of "C" and "D".

Illustration No. 48.

2nd, 3rd, and 4th lumbar vertebrae. Lateral view. Articulated. Compression between centra.

Above proves that vertebrae cannot move anterior, posterior, left, or right. There is still left but two possible additional directions: superior or inferior.

We have tried to create a "superior spinous process" as compared with its own and those spinous processes of vertebrae above and below. This brings into apposition anterior inferior rim of centrum of superior vertebra with anterior superior rim of centrum of inferior vertebra. Gravity weight of body mass above, plus normal movement, would tend to press downward and force alignment of these vertebrae.

Illustration No. 49.

2nd, 3rd, and 4th lumbar vertebrae. Lateral view. Articulated. Compression between centra.

We have tried to create an "inferior spinous process" as compared with its own and those spinous processes of vertebrae above and below. This brings into apposition anterior inferior rim of centrum of vertebra above, with anterior superior rim of centrum of vertebra below. Gravity weight of body mass above, plus normal movement, would tend to press downward and force alignment of these vertebrae.

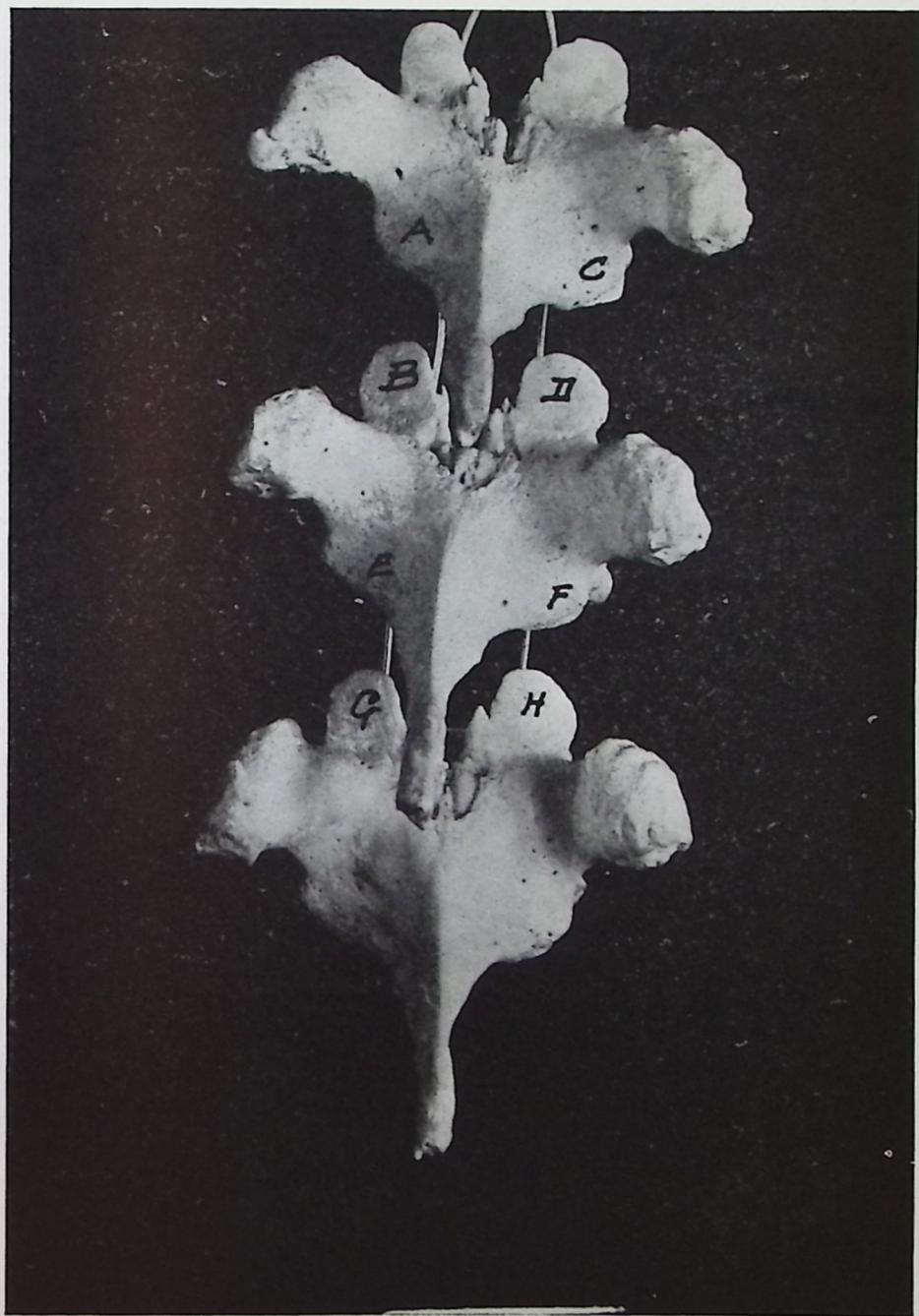


Illustration No. 39

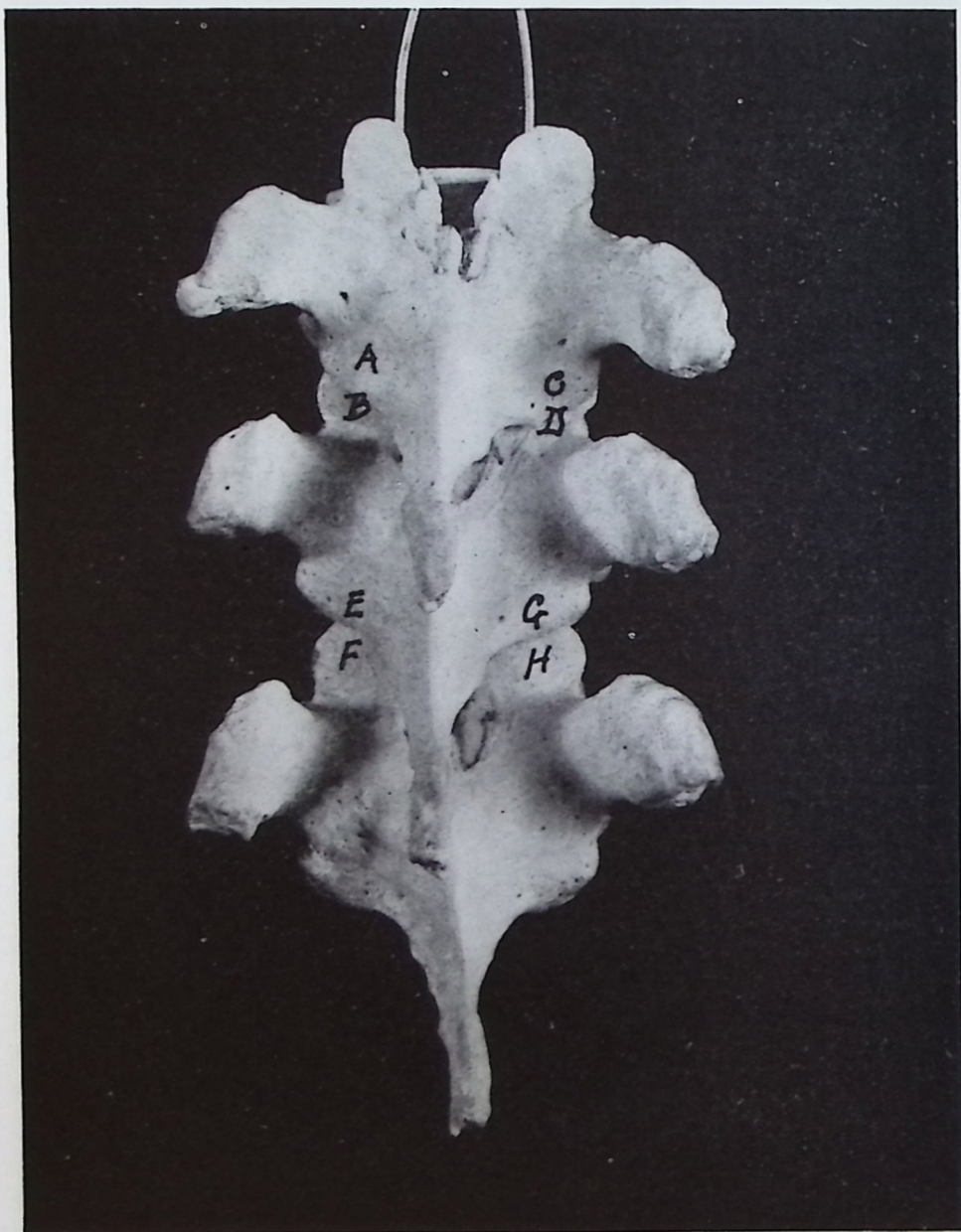


Illustration No. 40

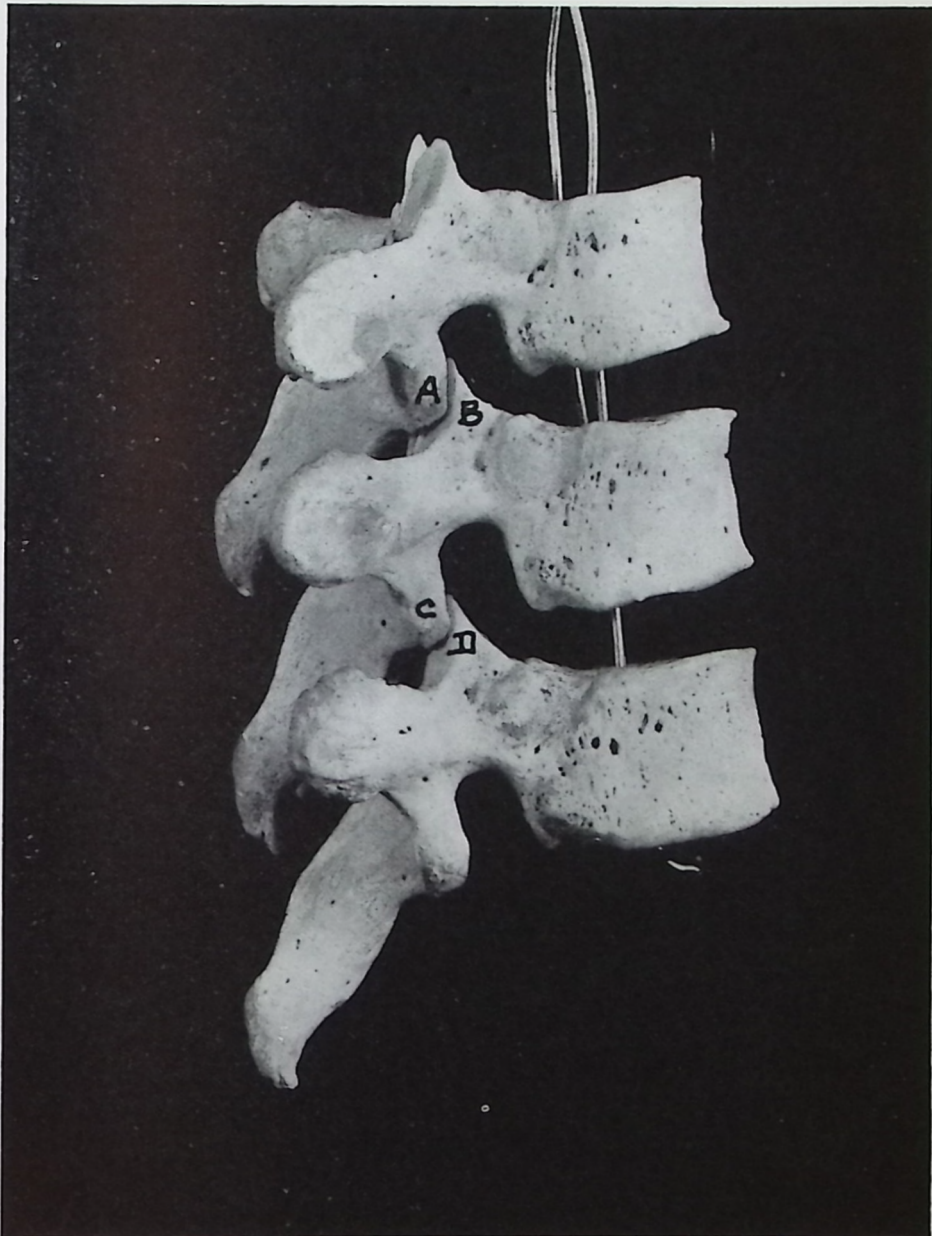


Illustration No. 41



Illustration No. 42

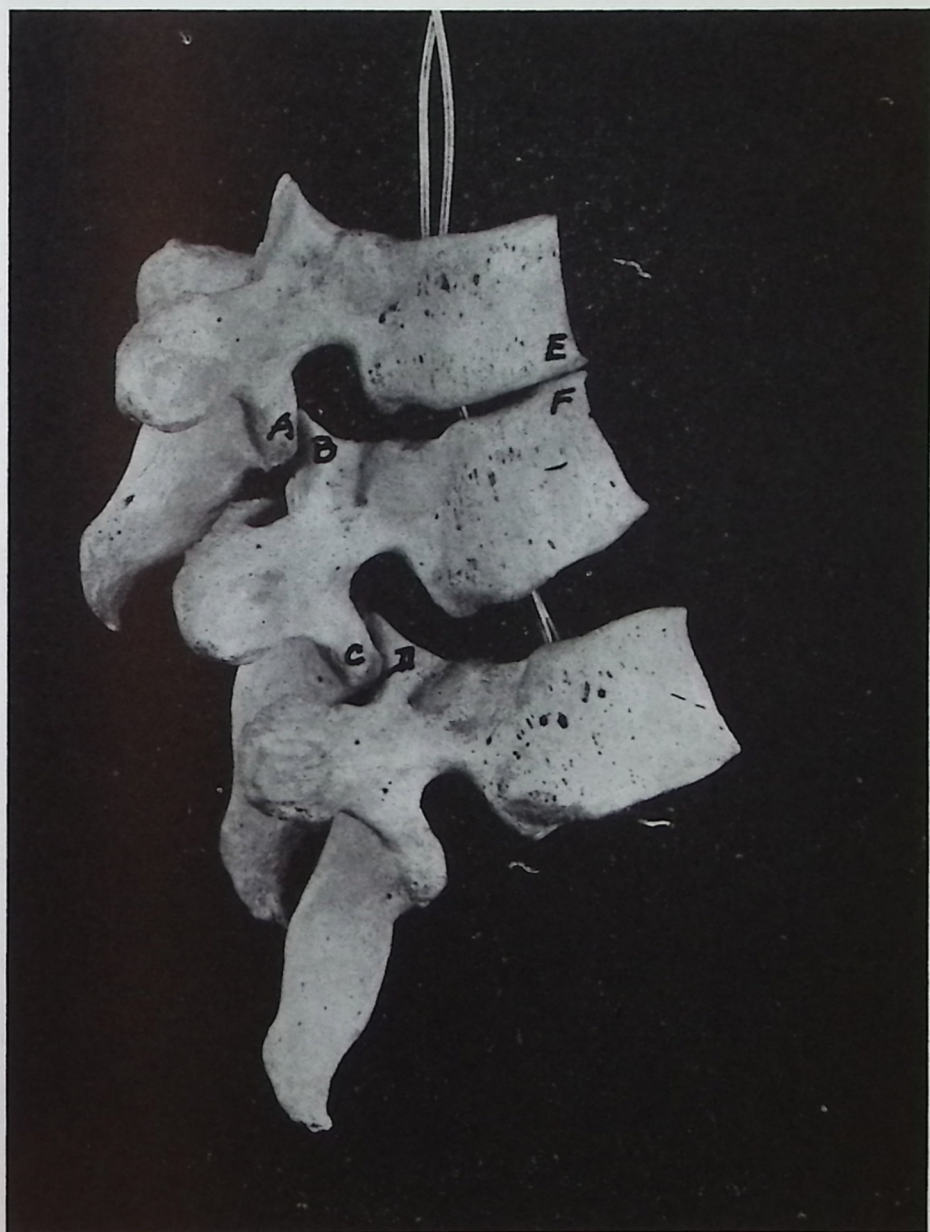


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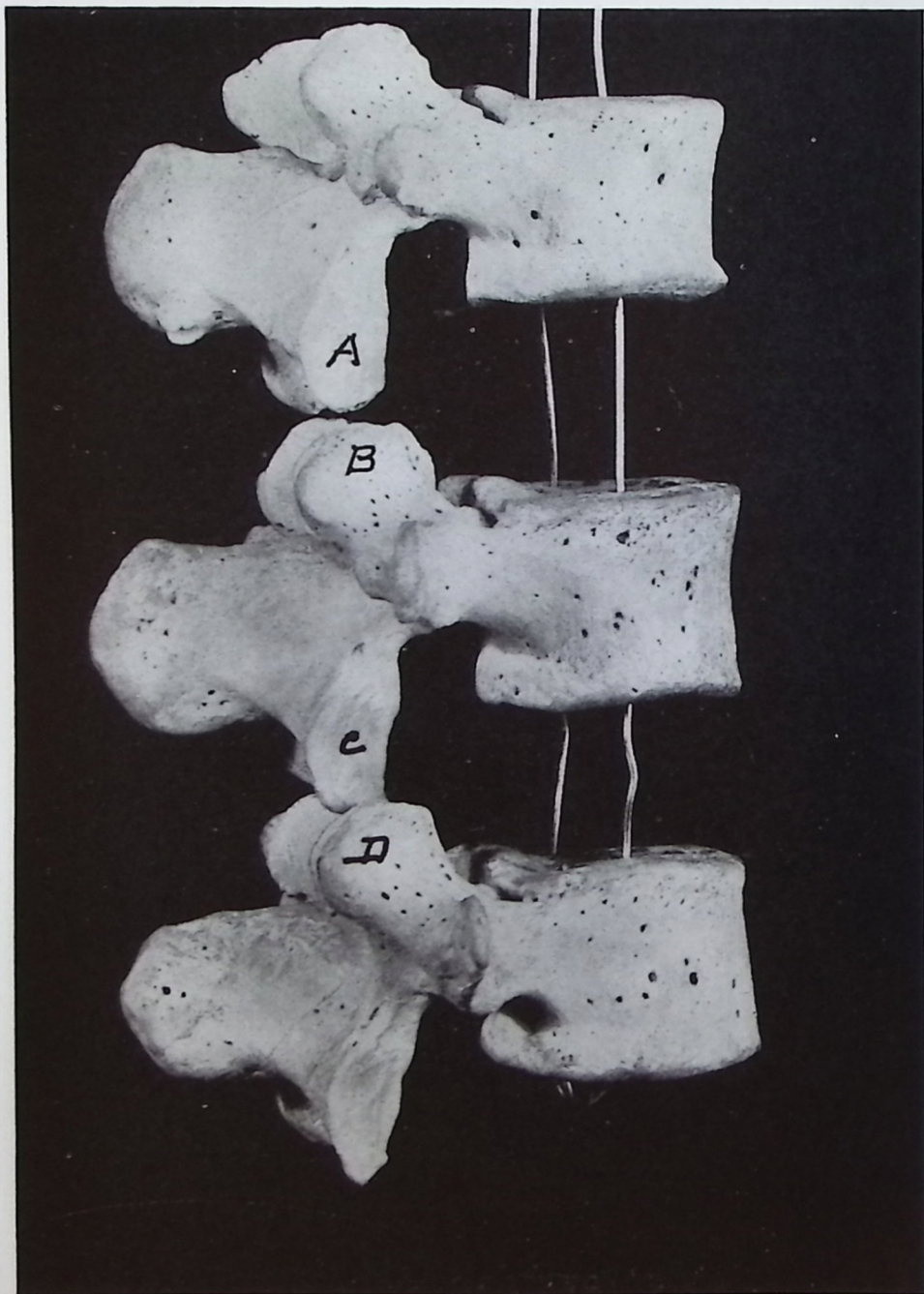


Illustration No. 44

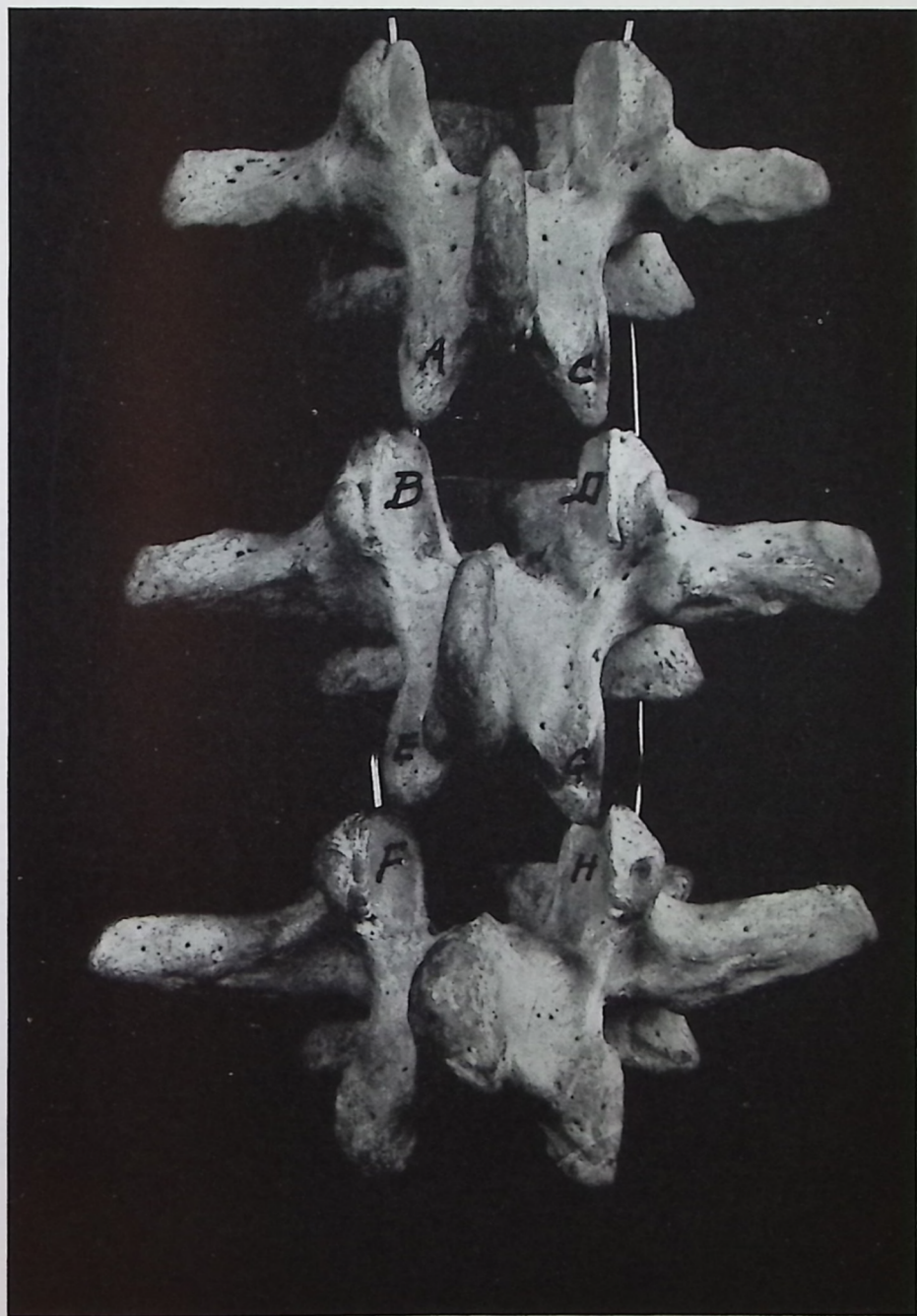


Illustration No. 45

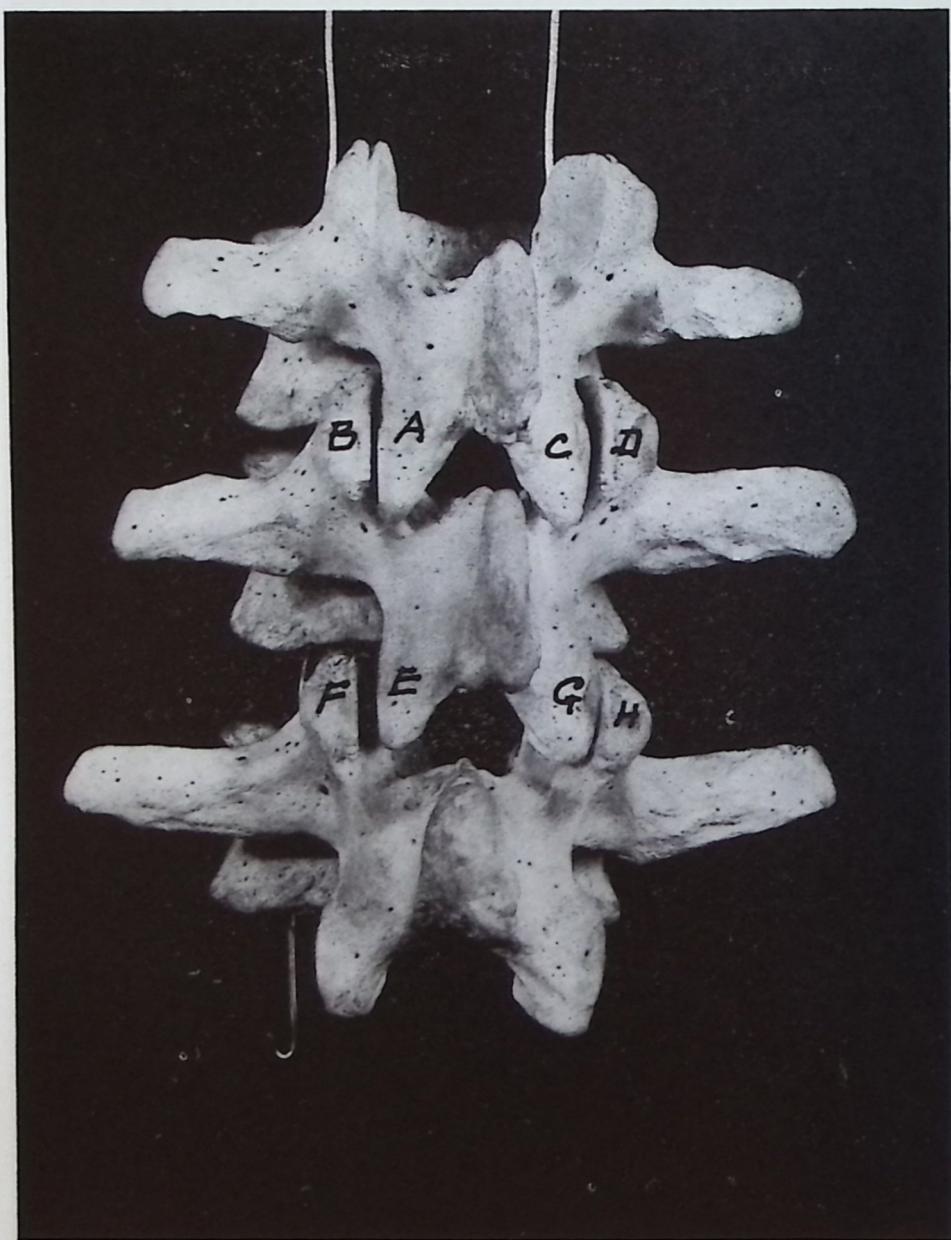


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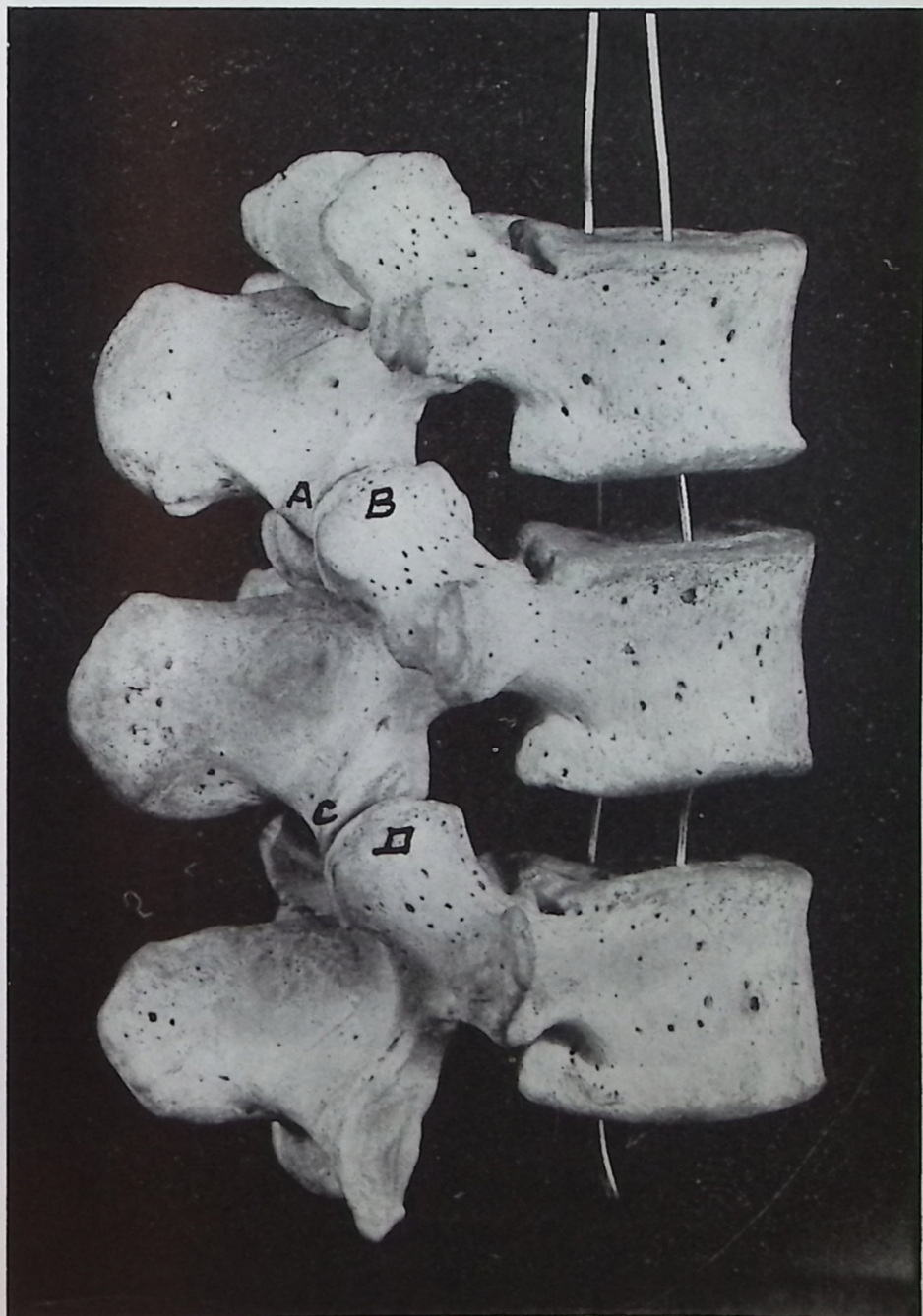


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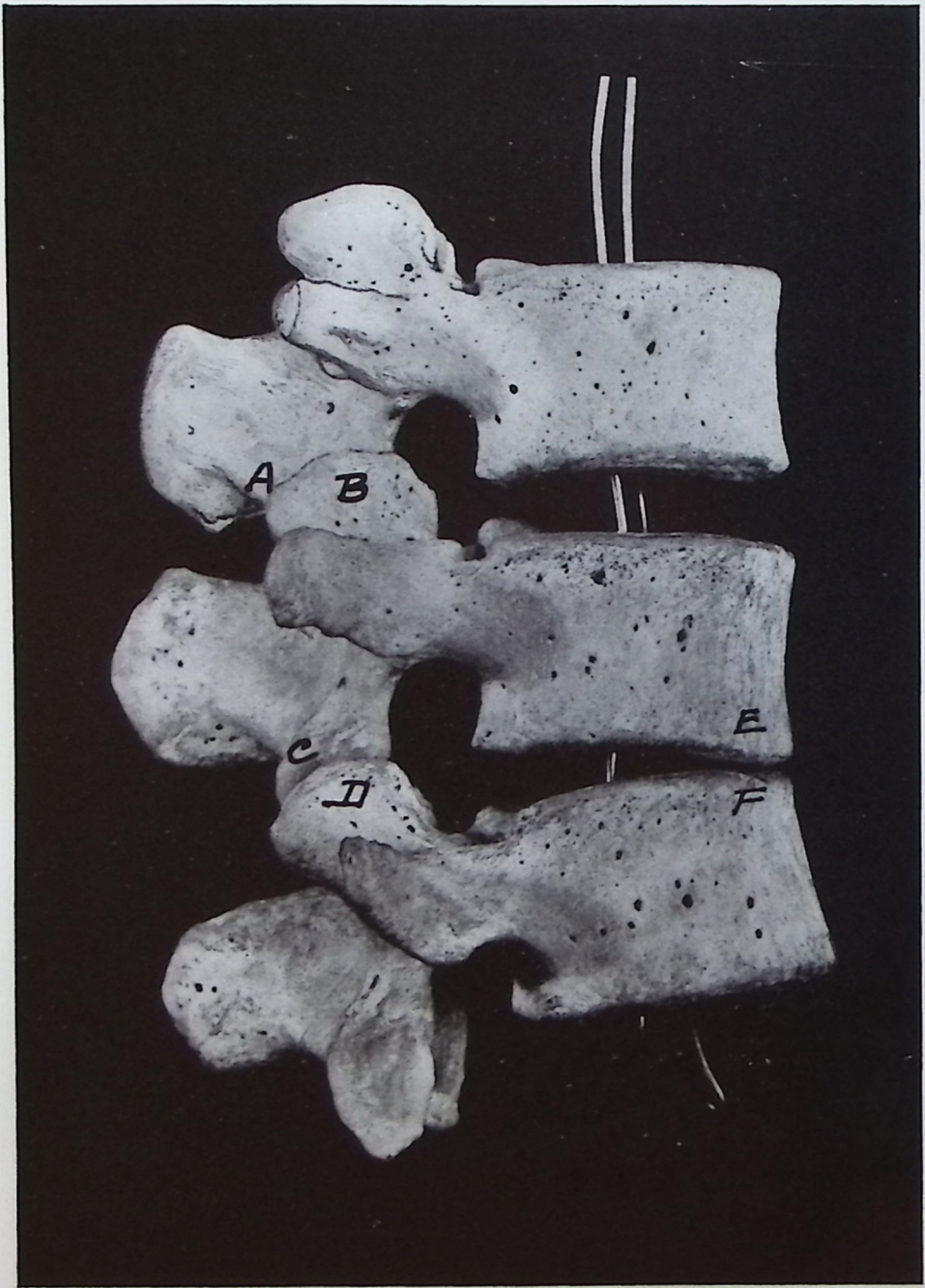


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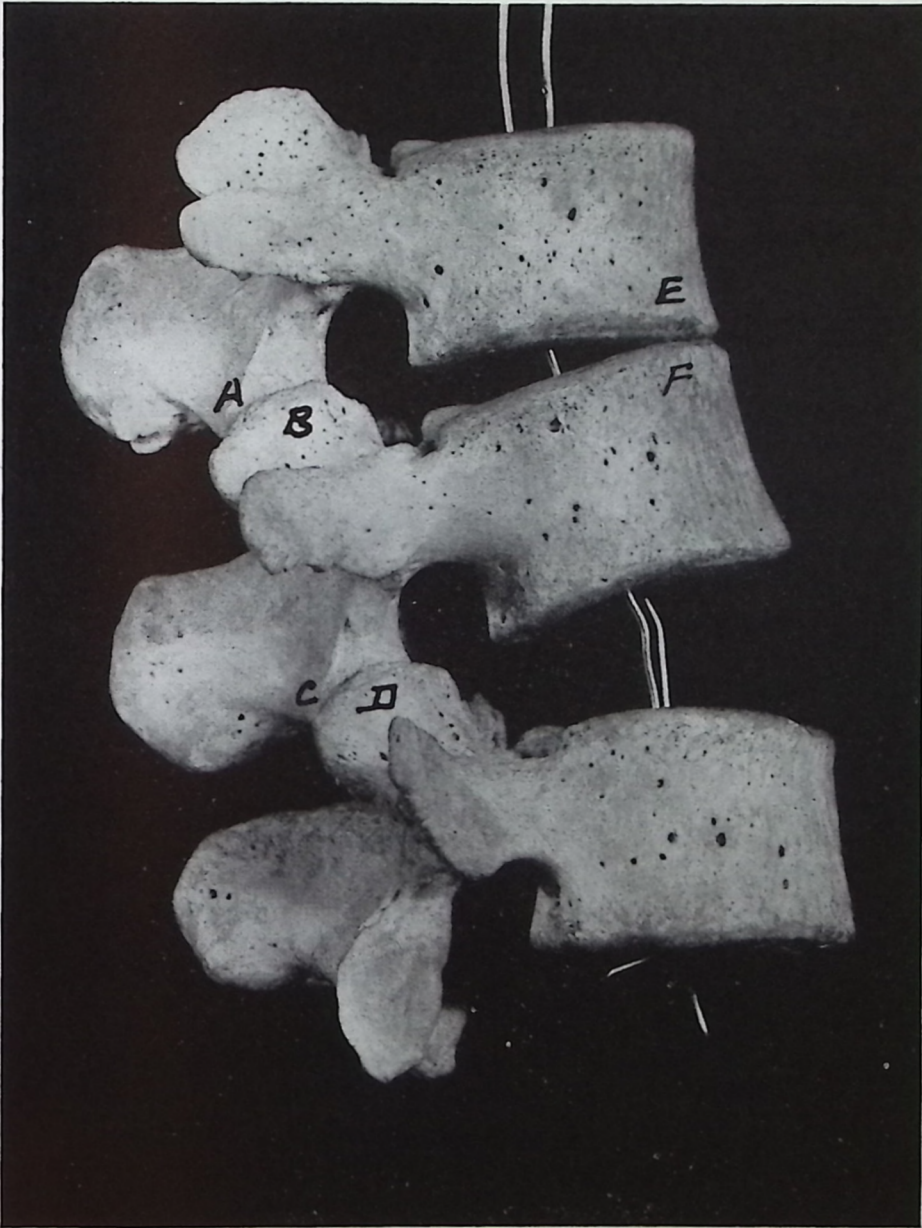


Illustration No. 49

ADAPTATIVE OR COMPENSATORY CURVES

For several years The PSC Spinograph Laboratories and our field research work have developed a technique for taking, developing and interpreting several thousand full length, single exposure, spinal column spinographs. 98% of these showed adaptative or compensatory curves in the several parts of those columns. Location, character, direction and degree of any or all compensatory or adaptative curves depends upon pivotal point of superior gravity of head and its condyles upon atlas, which might be left or right of center, or anterior or posterior (see description of atlas "posterior," Chapter VIII, under "A Vertebral Subluxation Must Have Three Directions") on condyles. Atlas wedge-side-slip subluxation shifts gravity weight balance point from side to side and from backward to forward or vice-versa, hence shifts position of head above and spinal curves below. Center of gravity weight balance depends upon degree of wedge-side-slip, degree of anteriority, degree of superiority, or inferiority. Generally speaking all articulations, in all people, between occiput, atlas and axis are normally builded alike. Specifically speaking, each person has a special size, shape, slant and slope of each articulation between occiput, atlas and axis which tends to produce individual adaptative and compensatory curves as result of his or her atlas or axis subluxations. General rules can be laid down for the many. Specific rules must be laid down, for the individual. This accounts for why we can establish a general rule for adaptative or compensatory curves and also why it is sometimes specifically opposite and contrary with same direction of atlas or axis.

General rule calls for a beginning cervical curve to left with L. HI head—a beginning cervical curve to right with R. HI head. All lower curves follow in sequence in sequential variance. Example: L. HI head, cervical curve to left, dorsal curve to right, lumbar curve to left, pelvis high on right, right leg appearing shorter than left. With R. HI head, each would be reverse. Specific application sometimes varies this rule to exact opposites. L. HI head could have a beginning cervical curve to right, etc.

For several years, the PSC Spinographic Laboratories have been exposing full 36" spinographs, taken with a single exposure, except for separate atlas and axis. A thotful study of these 36"

full-length pictures has revealed much in our research which fits here. If there exists a TRUE PRI specific axis subluxation, cervical will have a curve to the right, dorsal to left, lumbar to right; pelvis will be tilted high on right or low on left, with right leg shorter or left leg longer. If there exists a TRUE PLI specific axis subluxation, cervical will have a curve to left, dorsal to right, lumbar to left; pelvis will be high on left or low on right, with left leg shorter or right leg longer. There is more or less continuous adaptative or compensatory series of one-direction misalignments thruout entire length of spinal column. Sometimes it is very manifest; other times not so plain; but almost every picture, where there exists a major torque subluxation, has more or less of these conditions existing. IF it is true that these are one directional compensatory misalignments, and are NOT SUBLUXATIONS in any sense, then it is plainly obvious that THEY CANNOT BE ADJUSTED because they are NOT subluxations; and they SHOULD NOT BE ADJUSTED because they are compensatory misalignments. It is again the difference between KNOWING subluxations, where and when; and GUESSING subluxations, where and when.

(See Illustrations 145 to 174 inclusive as illustrative of subject matter now under discussion.)

Lest there be misunderstanding on facts, let me reassert and reaffirm that vertebrae can be and often are MISALIGNED below axis; such misplacements may be of individual vertebrae as well as many in a series of exaggerated curves. Spinographs reveal such DO exist. In the past we have seen these misalignments and interpreted them as subluxations in fact, attendant with all that a subluxation means to produce. Centra may be out of alignment with co-respondent centra above and below; spinous processes may be left or right in relation with co-respondents above and below; but in no instance have any such MISALIGNMENTS left their normal articulatory osseous intervertebral locks which prevent such.

There is a small group in our profession to whom everything is "spinal balance." That there are compensatory or adaptative abnormal curves in a spine is herein explained. To "adjust" to correct these abnormal curves to establish "balance," is to treat effects of a cause. Temporary, accidental, and occasional RE-

LIEF can be obtained. The "spinal unbalance" will return so long as cause that caused it exists and has NOT been corrected. Much better to adjust THE cause and let Innate Intelligence establish her own natural and normal balance.

There is another small group in our profession to whom everything is "general vertebral mechanical correction" of every vertebra in spinal column. They look, they see that every vertebra is misaligned. Why such does exist is herein explained. To "adjust" each vertebra, with an idea of aligning them, is to treat effects of a cause. Relief obtained may be temporary, occasional, and accidental, only to return because THE cause has NOT been corrected. Much better to adjust THE cause and let Innate Intelligence establish her own natural and normal alignment of each vertebra.

There is still another small group in our profession who have also observed this same series of adaptative or compensatory effects and symptoms that are sequences of a vertebral subluxation. They note, beginning from below, that one leg is shorter, pelvis is tipped, vertebral column has abnormal curves, muscles of back region are contracted or prolapsed or both, ligaments are taut or slack. Believing buttock region to be intermediary seat of balance control, they offer a secret method of tipping ligamentous "guy-wires" to establish muscular control, to create a normal straight spine, to level pelvis, to lengthen legs, to create health. That they observe these effects is to their credit. As a method of treating effects, it gets temporary results. It takes the average Chiropractor 3 to 6 months to realize that effects are NOT causes; that CAUSES cannot be corrected by treating symptoms; that THE cause is not basic in buttocks; that permanent health is established by adjustment of vertebral subluxation cause at inception—atlas or axis.

(See Illustrations 145 to 172 which portray adaptative or compensative vertebral column abnormal curves as shown in full length single exposure spinographs.)

(See Illustrations 173-176 of a typical before and after HIO case showing how adjustments compensate and adapt abnormal to normal without resorting to foreign methods herein mentioned.)

(For further study see "Habits," Chapter VIII.)

Suppose we were to remove the entire intervertebral disc from between any two lumbar, dorsal, or cervical vertebrae, then we

would only RESTRICT movement more than we have brot forth here under normal conditions WITH intervertebral discs present. If such intervertebral discs WERE removed, you decrease size, shape, and diameter of intervertebral foramina but you run directly into Swanberg's proof that the nerve is SO small and the opening SO large that you could not produce pressure upon nerves passing thru therein. If you were to SEPARATE vertebrae, beyond their normal range of motion, superiorly, (if such were possible), you tend to produce dislocation and you immediately get into possible traumatic effects of a field of surgery.

In above examples, we have accepted third lumbar; sixth dorsal purely as samples. Any other vertebra in same section would have answered as well.

Conditions which spinographs DO reveal, in almost EVERY A-P and Lateral set of views of vertebrae, other than Atlas or axis, are of 1 or 2 direction misalignment character. For this reason they DO NOT occlude a foramen and produce pressure. Take any 36" full-length spinograph of a spinal column and vertebral column is full of just such. In fact, every vertebra is out of normal alignment with co-respondents above and below; in one or two directions; mostly one, within their range of motion. It is these MISALIGNMENTS which some chiropractors misconstrue as subluxations, in fact. They are NOT normal; they ARE misalignments; they are NOT subluxations; they DO NOT occlude a foramen or produce pressures upon nerves, neither do they interfere with transmissions of the normal quantity of mental impulse supply. They may be permanent misalignments of one or two direction character, yet cause no harm to health or life. They do not need TREATMENT any more than any other EFFECT, the result of a cause.

A misalignment is an exaggerated movement of one vertebra upon another, or a series of vertebrae upon each other, within the range of their articulatory locks.

Osteological specimens of sections or total spinal column, where curvatures exist (some of which we show in Illustrations 10 to 17, which could be amplified in hundreds) divide themselves into two groups:

1st. Those in which there IS a three-direction torqued subluxation of atlas or axis. No subluxation or subluxations exist-

ing below. The curvatures—and it is questionable whether that is now the correct term—below are a marked series of exaggerated normal movements of one vertebra upon another, each within the range of its normal locked articulation, the sum total of which finally develops into major and minor curves with adaptive curves. These are not only “curves” but they are exaggerated or reversed “curves.” They can be lordotic, scoliotic, kyphotic, or rotatory. In this type of case, the entire length of each curve, regardless of direction or degree, is made up of a series of multiplied increased normal movements, each exaggerated within its range, without being a subluxation or dislocation, none of which has gone beyond the natural normal lock except in an exaggerated form of the articulations as described in this article.

2nd. Those in which there IS a three-direction torqued subluxation of atlas or axis. No subluxation or subluxations existing below. The curvatures—and this is the proper term as applicable to this type—do exist made up entirely of malformations of the actual normal shapes of some or all portions of the vertebral structure of the vertebrae which in turn do permit a forced exaggeration of the normal articulatory motion between them within their range, without being a subluxation or dislocation, none of which has gone beyond the natural normal lock of the articulations as described in this article. They can be lordotic, scoliotic, kyphotic, or rotatory. They can be osteomalacia, caries, necrosis, tuberculosis, etc. It is the pathology of the osseous structure of the vertebrae which has broken down its size, shape, and form, that creates the malformation of direction of curvature in each such instance.

It is possible to have the first group without having any of the second present. It is not possible to have the second, without having some of the first.

(A study of Illustrations 10 to 17 illustrates both types. Illustration 10, in its cervical and lumbar regions has the 1st type. The acute angular kyphosis, in center dorsal, is the 2nd type. Illustration 11 is an enlarged view that shows the 2nd type markedly. It also portrays portions of the 1st type above and below. Illustration 12, except for the central portion, is of type 1. Illustration 13 is an anterior view of the center section and shows type 2. Illustration 14 is largely of type 2. This is more clearly shown in Illustration 15. Illustration 16, in the lower section portrays type

1, and the angular section shows type 1. Illustration 17 refers back to specimens 10 and 11, except in cross section, which portrays this fact clearly. The cervical region is a series of exaggerated movements, except for the torqued three-direction subluxation at axis. The central section again shows the second type.)

The meric system was born, continued to exist, and has been generally used for years as an adjusting guide by virtue of the theory that EVERY and ALL movable vertebrae in spinal column could be and frequently were subluxated; that these different "subluxations" located at various and multiple places introduced all known elements that made them subluxations in fact, hence all were to be adjusted at designated places to "cure" disease. It is now settled that no lumbar, dorsal, or cervical vertebrae (below axis) can move other than within range of their articulatory locks. To go beyond, is to have dislocation. If it is less than a dislocation, it is within locks. This means finis to justified use of meric system as being a locating factor for adjusting. It came at proper time; it served its purpose; it leaves behind a new, accurate concept of neurological distribution. Articulatory locking of vertebrae now repudiates its value as an adjusting guide. I regret the passing of this medium as a stepping-stone to a greater concept. I was its scientific parentage. It was my mental-child. I nursed and raised it thru the years it needed being fought for. But truth demands that error must pass and facts replace opinions as understanding grows.

It is the THREE direction subluxation that DOES torque a misplacement to such a degree that it DOES become a subluxation. It can be safely said that THE ONLY PLACE where we can get a THREE direction torque misalignment which constitutes a subluxation in fact, is at occiput, atlas or axis.

(Illustrations 18 to 25 will give a clear exposition of what we have suggested here in statement of words. Suggest you observe them, for the moment, as you read copy.)

CONSISTENT INCONSISTENCIES

Atlas wedge-side-slips in relation BETWEEN occiput above and axis below. THE HEAD is not subluxated in relation TO atlas. When atlas wedge-side-slips right, it is high on right and low on left; head appearing to have moved left, being low on right, high on left.

We speak of R. LO or R. HI, referring to position OF HEAD. How can HEAD be HI or LO and yet NOT move HI or LO?

This consistent-inconsistency is a question of whether you speak of position of one segment by itself, its relation TO one other, its relation BETWEEN two others, its relation to THE TOTALITY of spinal column, or in terms of plumb or level lines.

Atlas can be subluxated ONLY anterior from axis. Atlas cannot be subluxated posterior because it locks against odontoid process of axis. Atlas can be subluxated anterior and superior; or, anterior and inferior.

Inconsistent as it is, atlas can be anterior superior but when it is anterior AND INFERIOR it is POSTERIOR and inferior. As atlas rocks superior on anterior it rocks anterior. As atlas rocks inferior on anterior, it automatically rocks inferior AND POSTERIOR, notwithstanding the ONLY possible subluxation of atlas is anterior FROM axis.

This consistent-inconsistency checks when we say, when atlas is anterior superior, it is superior and anterior of both occiput above and axis below. When atlas is anterior and inferior, it is POSTERIOR ON occiput AND anterior OF axis.

Illustrations 113-114.

A group of 10 axes selected from The Palmer School of Chiropractic Osteological Studios. Each of these axis vertebrae has a bent spinous process—some more, some less—as indicated by the plumb line drawn thru the direct superior-inferior center.

Illustration No. 115.

Specimen showing the six cervical vertebrae and the inferior portion of the occiput, with spinous process and posterior arches of the vertebrae removed; showing the posterior common ligament thrown backward and downward, and the superior portion upward. The check, or lateral odontoid ligaments are exposed on each side, with the transverse ligament flattened and spread out from either side of the axis to the inner surface of atlas, and the middle odontoid or suspensory ligament extending from the odontoid process to the anterior margin of the foramen magnum.

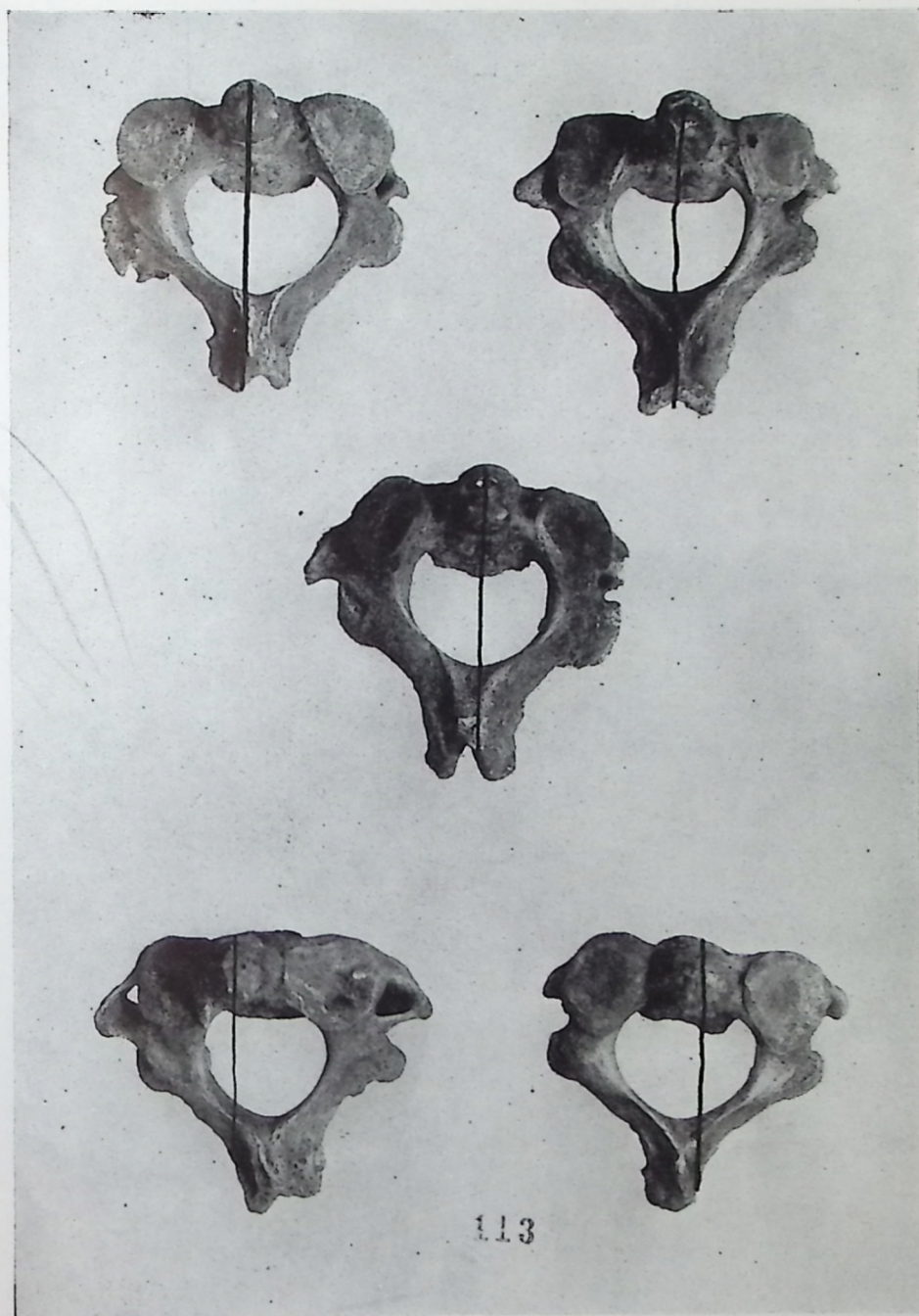


Illustration No. 113

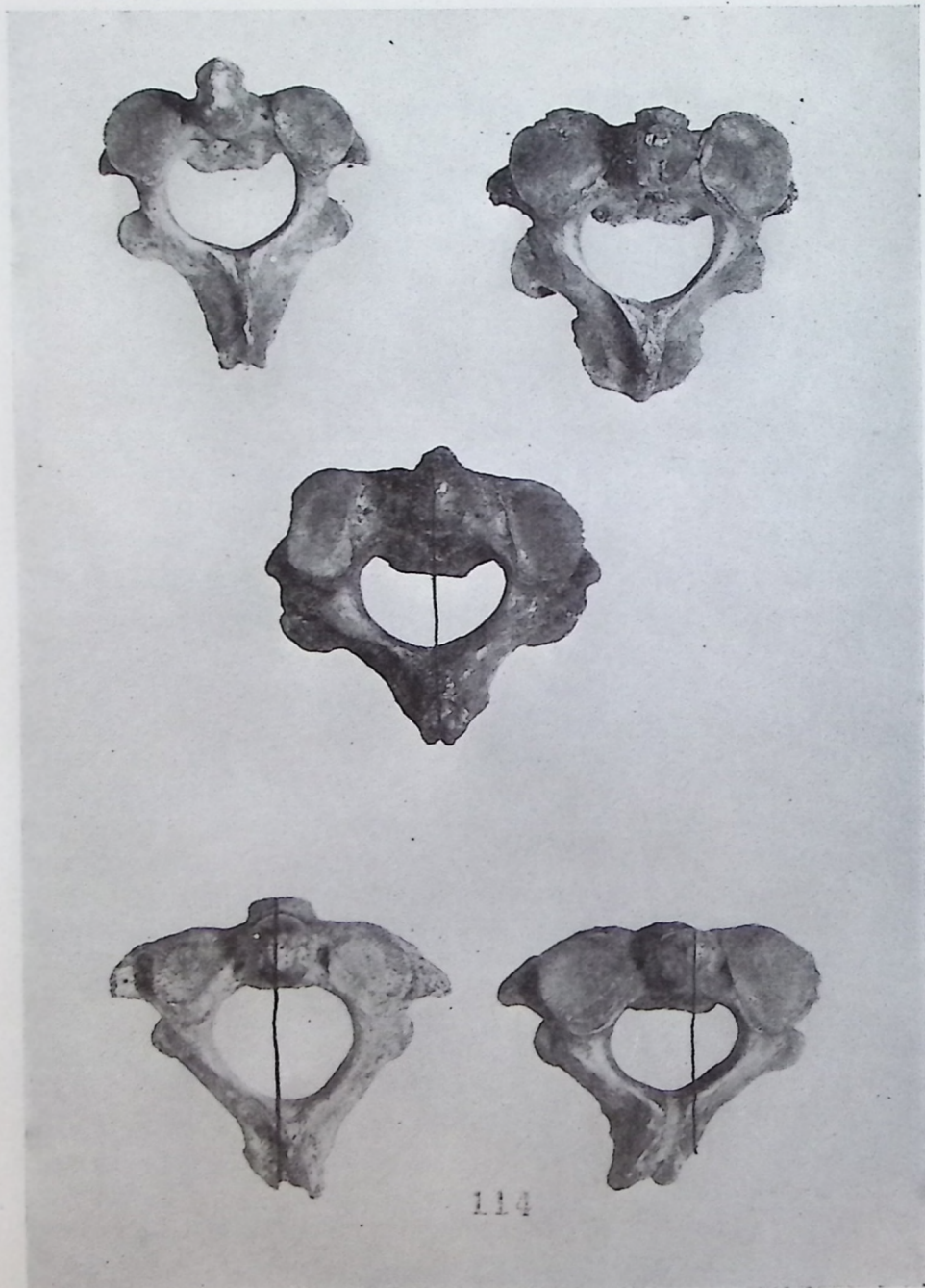


Illustration No. 114

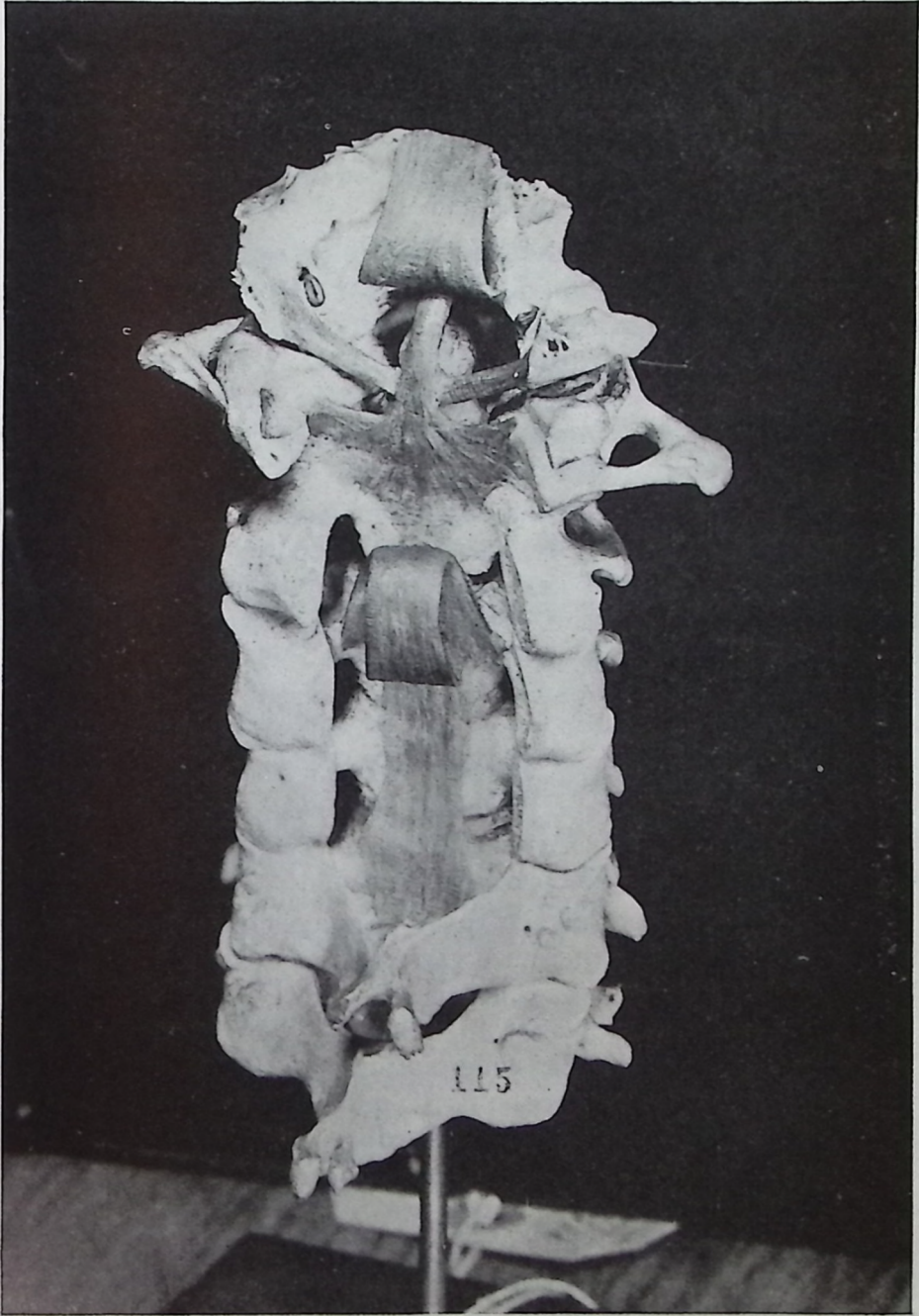


Illustration No. 115

HABITS

Thruout the text we have occasionally mentioned "adaptative" or "compensatory" curves or curvatures following torque subluxation. We see the net result, note and mention it. While a part of permanent condition, we give little thot of what was behind it from beginning, that changed normal to present abnormal, if such it be.

We are a dual being, educated and innate, external and internal. Each of these personalities that compose us as a composite unit, shapes and forms these adaptative or compensatory conditions. Educated has to do with EXTERNAL adaptations and compensations. Innate has to do with INTERNAL adaptations and compensations. Some people call these "adaptations" and "compensations" by term "habits."

Many people think of "habit" as some form of action more or less purposely or carelessly assumed by repetition, without purpose or reason. This is never true, regardless of location, character, or degree of "habit"; whether it be sexual, drug, or peculiar carriage of some portion of body. "Habits" are normal adaptations to some abnormal, contracted, or pathological condition.

Example: A sensitive and sore corn on foot. Person limps. Limp is assumed to be a "habit." Soreness occasions limping lightly on foot WITH corn and throwing weight on foot WITHOUT. If there were no corn, person would NOT limp.

People assume positions, postures, carriages, movements which they have found by experience give greatest ease and rest with least pain, discomfort, and suffering.

We herein refer to "right high head"; "left low head", etc. With wedge-side-slip atlas subluxation or PRI true axis, etc., with pressure, interference, etc., it can be understood that the individual has discomfort, pain, suffering, inconvenience, etc. He (or she) has found that tilting head high on one side or low on other gives relief, less discomfort and suffering. By so doing it relieves; hence "habit" of carrying head this way or that. Position of head above is, in part, adaptative or compensatory to subluxation below, as much as vertebral curves below are, in part, adaptative or compensatory to subluxation above.

Innate Intelligence is internally constantly adapting various parts of our bodies to best release pressures without Innate Intelligence being able to adjust subluxation and releasing all of it. As soon as subluxation is adjusted, pressure released, restoration of transmission takes place, "habit" disappears.

(Study previous section of article preceding this, where this subject is more extensively elaborated.)

CARE IN ESTABLISHING BASIC FACTS

Accuracy IS important in EVERY step of efficient and competent work. The ultimate objective is to get the sick person WELL. This cannot be done, backing up in our analysis, unless adjustment is given with that "extra something," with "staying-put" value. This means that adjustment must untorque the torqued subluxations, which means that adjustment must be given in right direction from correct analysis of spinographs, which contains the presumption that spinographs were correctly taken; which leads to the fact that SPINOGRAPHS CAN BE TAKEN WRONG AND EVERYTHING THAT FOLLOWS CAN BE WRONG. I am not unmindful of the possible statement being made about this present work by some of our ancient-thinking contemporaries that "anybody can take any kind of a picture he wants, according to what he wants it to show." I have not been exposing, developing, reading, and analyzing X-ray plates and films for 23 years without knowing that angles of rays and twists of heads and bodies can be so placed that you can practically produce anything you want a film to show. However, I have been exposing, developing, and analyzing X-ray plates and films long enough to know that pictures can be produced that DO accurately, competently, and honestly reproduce exactly what is internal in the human body. It is that accuracy and honest reproduction that we have so faithfully worked for in The PSC X-ray laboratories for 23 years to reproduce. The course of instruction in X-ray technique in The Palmer School of Chiropractic X-ray Laboratories calls for ABSOLUTE ACCURACY of placing the body of the patient, regardless of whether it be prone or sitting up; on an A-P view of the entire spinal column or a lateral cervical. By "accuracy of placing the body of the patient" is meant, always in a natural position consistent with the unnatural conditions he or she has in that spine.

Nothing is done to interfere with what is IN that spine, in this placement of the body on table; but the body with all its irregularities, misalignments, subluxations, etc., IS ALWAYS PLACED FOR EXPOSURE IN THE SAME PLACE so that if many PSC operators were to expose the same patient at different times, they would ALWAYS get THE SAME placement, none interfering with what there is to be "shot"; all coming out with plates or films showing EXACTLY THE SAME THING, whatever it was, inside that body. We have films sent for analysis; same person; same portion; sets taken at different times, showing something different; one group showing a TRUE PRI; the other showing it PLI, etc. As he placed the head, that is exactly WHAT he did and HE didn't "place" it the same both times. We here LET THE PATIENT PLACE HIS OWN HEAD, NECK, OR BODY. All that WE do is to see that it is ALWAYS placed in accordance with certain LOCATIONS on the table. This accuracy and exactness to careful placement means that our plates will faithfully and honestly reveal what we need to know—the position of the subluxation—to be of service to the sick person in helping him get well. Many Chiropractors lay any case down any sort of way and expect to do HIO work with competency. If the patient HAS a true PRI axis and the spinograph carelessly-taken shows it PLI, the case is adjusted from PLI and gets worse, WHO gets the blame? The HIO, OF COURSE! We urge all who take spinographs to be accurate. If they don't know HOW to be accurate, they should come to The PSC and learn.

(See and study Illustrations 50 to 59 including all conclusions on sets A, B and C.)

Your patient correctly SEATED on spinographic table will be assisted to prone position by hands of spinographic operator who should be VERY careful NOT to pull shoulders towards him when assisting to prone position. If he ever so slightly tends to pull shoulders towards him (standing at head of table and at head end of case), he will pull out the normally-abnormal adaptive or compensatory curves thruout length of that spinal column. His sole objective in taking full-length single-exposure spinograph is to get IN those naturally-abnormal curves. To pull them out is to destroy reproduction of that which you seek to find to know exists. If patient is permitted to lie down without

stretching, either by himself or with your aid, adaptative or compensatory curves will be observed in practically every case that has an atlas or axis major subluxation, even to tilting of pelvis and shortening of one leg.

(See further discussions of this same subject in another article in this Chapter as well as Chapter IX.)

(See Illustrations 145 to 172 which portray adaptative or compensatory vertebral column curves as shown in full-length, one-exposure spinographs.)

It is false economy to try to take both an A-P and Lateral view on one film, regardless of whether it be small or large. Not less than TWO 8x10's should be exposed. One 8x10 for an A-P view, another 8x10 for the lateral. In exposing your film so center that you get a fair share of inferior of occiput ON each film. We need the occiput to give us our osseous land-mark bearings on correct readings.

CHAPTER IX.

INTERPRETING SPINOGRAPHS

(Read also "Care in Establishing Facts" under Chapter V. Check Illustrations 50 to 55 with descriptive text.)



WHAT, then, should we **NOW** seek to see? Take a group of **LATERAL** spinographs of the cervical region—say not less than 50—100 would be better. Sort them over hurriedly. Set apart those which seemingly present the greatest irregularities in misalignment in the superior cervical regions. Look at this reduced group carefully, thoughtfully. Put them in the view-box, one by one. Do not sit close to them, but stand back. Instead of studying detail, give them a general-contour-once-over. Get a long-range perspective of the entire lateral vertebral cervical lines. Gradually reduce the area until you have reduced it to the region of the superior cervical vertebrae. Do they present anything in particular? Is there something unusual in their comparative positions which strikes you as irregular? I suggest culling over 500 to get a marked small group, for the most of them **AT FIRST** might not seem to exhibit the fact we now bring forth. **ALL** will contain the same conditions, the smaller group will make them easier to see for the beginner. The small group, with **EXAGGERATED** conditions, will exhibit the fact we now present so plainly, that there will be little if any doubt in your mind. Once you see it in the small, exaggerated group, knowing then what to look for, you will see it in all.

Hastily pass the small group of **LATERAL** views before you. **WHAT DO YOU SEE? (SEE WHAT YOU SEE WHILE YOU'RE LOOKING AT THEM!)** Somewhere in the region between occiput and atlas

—atlas and axis

—axis and third cervical, you will see a **KINK, TWIST, WRENCH, TORQUE** which makes a more or less angular distortion **OR BEND** in the general contour between two of the above. This kink, twist, wrench, or torque is **MECHANICAL**. **IN NO OTHER PLACE IN THE SPINAL COLUMN WILL IT OR CAN IT BE MECHANICALLY FOUND.** It will exist pathologi-

cally. Usually this is between the occiput and atlas; atlas and axis. Once you determine the kink, mark outline of size and contour of spinal canal. Mark outline of position of odontoid process of axis. Study deeply into that spinal canal and see HOW THE ODONTOID PROCESS IS SQUEEZING, COMPRESSING, AND OCCLUDING THAT SPINAL CANAL. The odontoid process may be posterior; twisted in or lateral to its normal position, but in some form it is ALWAYS squeezing INTO THAT SPINAL CANAL, shutting off flow of mental impulse supply inferiorly, and damming back into brain superiorly. Study carefully the effect between inferior of magnum foramen and superior of atlas, when atlas wedge-side-slips in any one of its four possible subluxations and you again see how pressures do occur on spinal cord, shutting off flow of mental impulse supply inferiorly, and damming back into the brain superiorly. Desiring to study the matter further, get an ordinary normal atlas and axis, hold them in your hands, distort them as your spinograph reveals, and see what you produce. You thus, for the first time, account for the multiple spinal cord interferences which we read at various places below; how we account for the existence of cica-

Illustrations 116 and 117.

Lateral view of atlas and axis, showing perpendicular line drawn thru odontoid of axis. Level lines drawn thru base and spinous process of axis. At right angles to each other, they show comparative shifting of position of one also equally shifts other line. To shift the spinous process inferior is to shift the odontoid posterior. Lines are compensatory. Plumb and level lines show possible differing degrees of subluxation of axis posterior and inferior.

A-P view. Plumb line thru center of axis, would be median line if vertebra were normal. The axis can be subluxated to left or right, in varying degrees. Lines are drawn to illustrate these degrees and how they would be expressed in terms.

Joining the lateral AND antero-posterior views, we could have a posterior, inferior, left OR right subluxation of the axis.

For instance—PIR double plus. PI double plus, L plus. The combinations are many, and spinographs prove them to exist in reality.

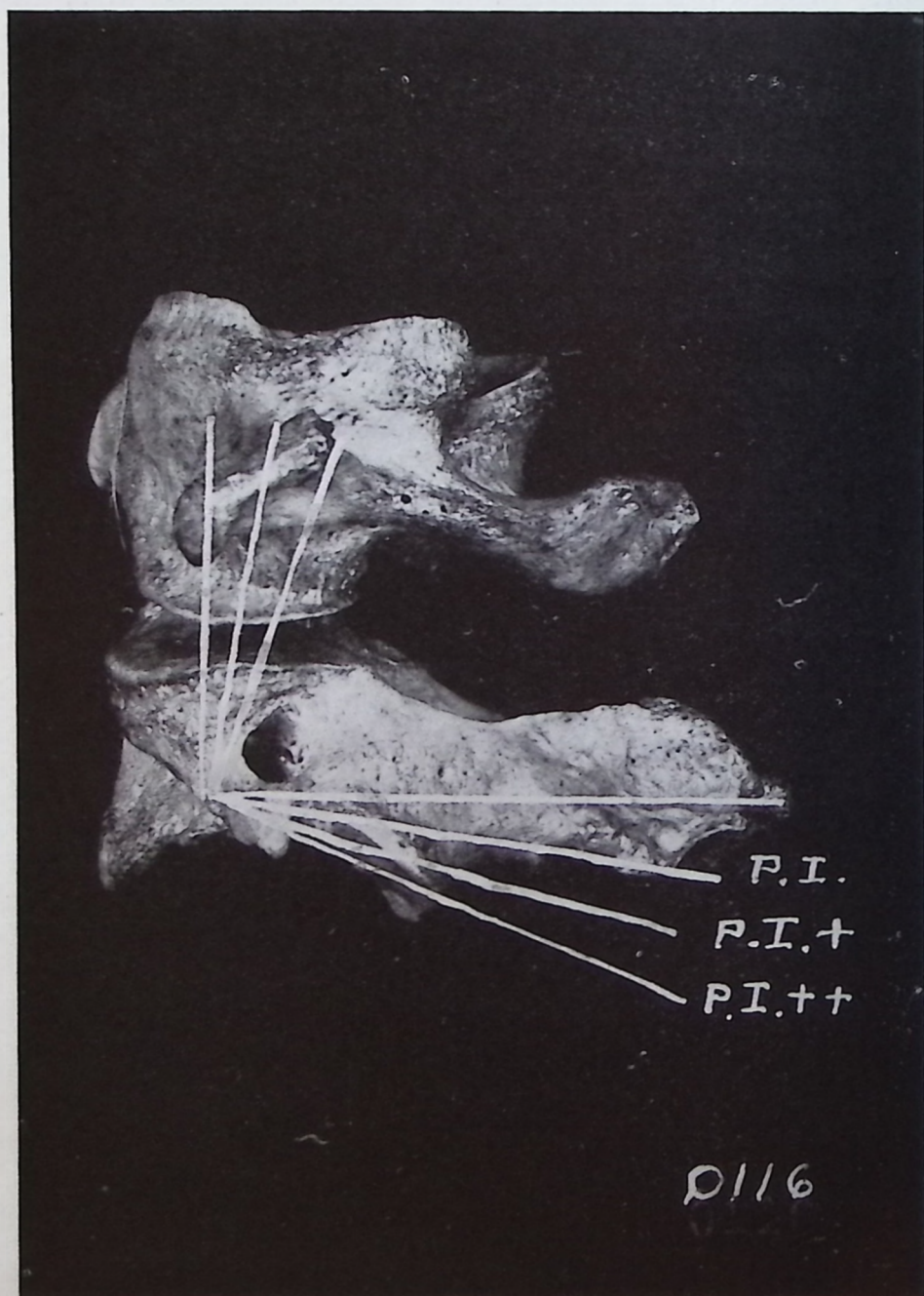


Illustration No. 116

trices or scar tissues placed upon or around the cord at places of friction in impingement of movement of one vertebra upon or around the other in their many varied movements within the subluxation range of motion; (see "What Is Behind the Hobbing, Roving, or Roaming of Vertebral Subluxations?", page 76, DISCIPLINING THE HOUR.) which accounts for the possibility of so many dis-eases caused below by ONE place above, regardless of the distribution of the nerves below in their millions of ramifications.

Many think that when we use the term "pressure", we mean bone substance actually squeezing nerve substance. Vertebral subluxation so decreases size, shape, diameter, and circumference of lumen that, there being no escape of spinal cord substance passing thru the foramen, it produces a CONstriction around spinal cord, thereby creating "pressure" upon it. Without constriction, pressure has no meaning. That is why no soft tissue structure can produce "pressure" upon other soft structure passing thru it. It always has an avenue of escape. Contractured muscles cannot produce "pressure" upon nerves passing thru them, every such nerve has an avenue of escape. A like condition does NOT exist in the magnum foramen. It is one solid bony ring above and another bony ring below, between which is CONstriction from which the spinal cord has no escape; therefore "pressure."

(As you read this copy, study it carefully. When you get thru this Chapter, I suggest you take time, go back to Chapters of actual spinographic case torque subluxations, check up statement made here, with facts re-

Illustrations 118 and 119.

Lateral view. Differing plane lines, including the normal plane line. Shows different degrees of possibilities of subluxations atlas can be inferior, and methods of expressing same. Naturally an anterior arch is subluxated inferior, posterior arch will compensate to opposite direction.

A-P view. Shows normal plane line and the relative degrees to which the atlas can be inferior on left.

Joining the lateral AND antero-posterior views would mean an anterior, inferior, left subluxation of atlas, in differing degrees.

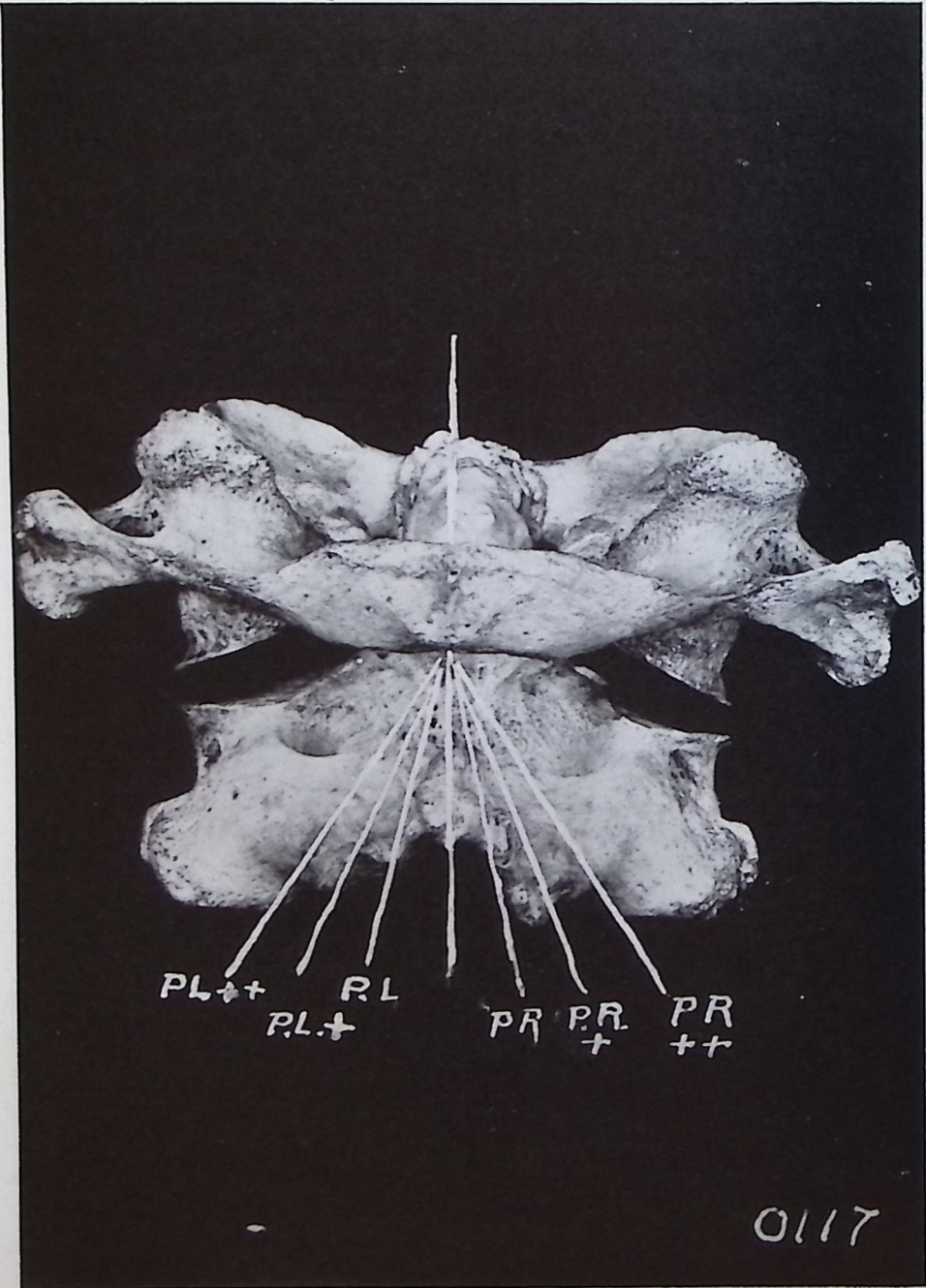


Illustration No. 117

vealed there. Work back and forth in this way, checking language against facts; case conditions against language. This will clarify the knowledge we try to impart.)

A vertebra is an osseous or hard structure. Spinal cord or spinal nerves are soft structures. Vertebrae, as hard structures, articulate each with the other. This articulation of one vertebra with the other is a mechanical movement; both in rotation, extension, hyper-extension, flexion, and counter-flexion. It is possible to have such an exaggerated torqued subluxated position of a vertebra that it will produce a direct hard structure pressure upon the soft structure comprising surrounding meninges of spinal cord; pass thru it and create pressure direct upon spinal cord nerve fibres of which it is composed. As all vertebral subluxations have motion in any or all directions mentioned, they do create friction of motion within their abnormal subluxated range of motion. (See citation in paragraph above.)

This friction produces a callous growth to adaptatively reduce the element of injury. A like comparison can be made where a tight shoe misaligns a toe joint, be it little toe or big toe. This misaligned joint creates a bump which rubs against the tight shoe every time the foot raises or lowers. To reduce damage of friction of hard shoe leather against soft skin tissue, Innate Intelligence soon builds a callous, concentrically builded like layers of an onion. In time, this becomes a "corn." Given time, the callous GROWS to such a thickness that, within itself, IT SOON CREATES a local pressure because of the size of its own growth. This becomes likewise true of scar tissue, cic-

Illustrations 120 and 121.

Lateral view. Differing plane lines, including normal level plane. Shows different degrees of possibilities of subluxations atlas can be inferior, and methods of expressing same. Naturally, as anterior arch is subluxated inferior, posterior arch will compensate to opposite direction, viz., superior.

A-P view. Shows normal plane line and the relative degrees to which the atlas can be inferior on right.

Joining the lateral AND antero-posterior views, would mean an anterior, inferior, right subluxation of atlas, in differing degrees.

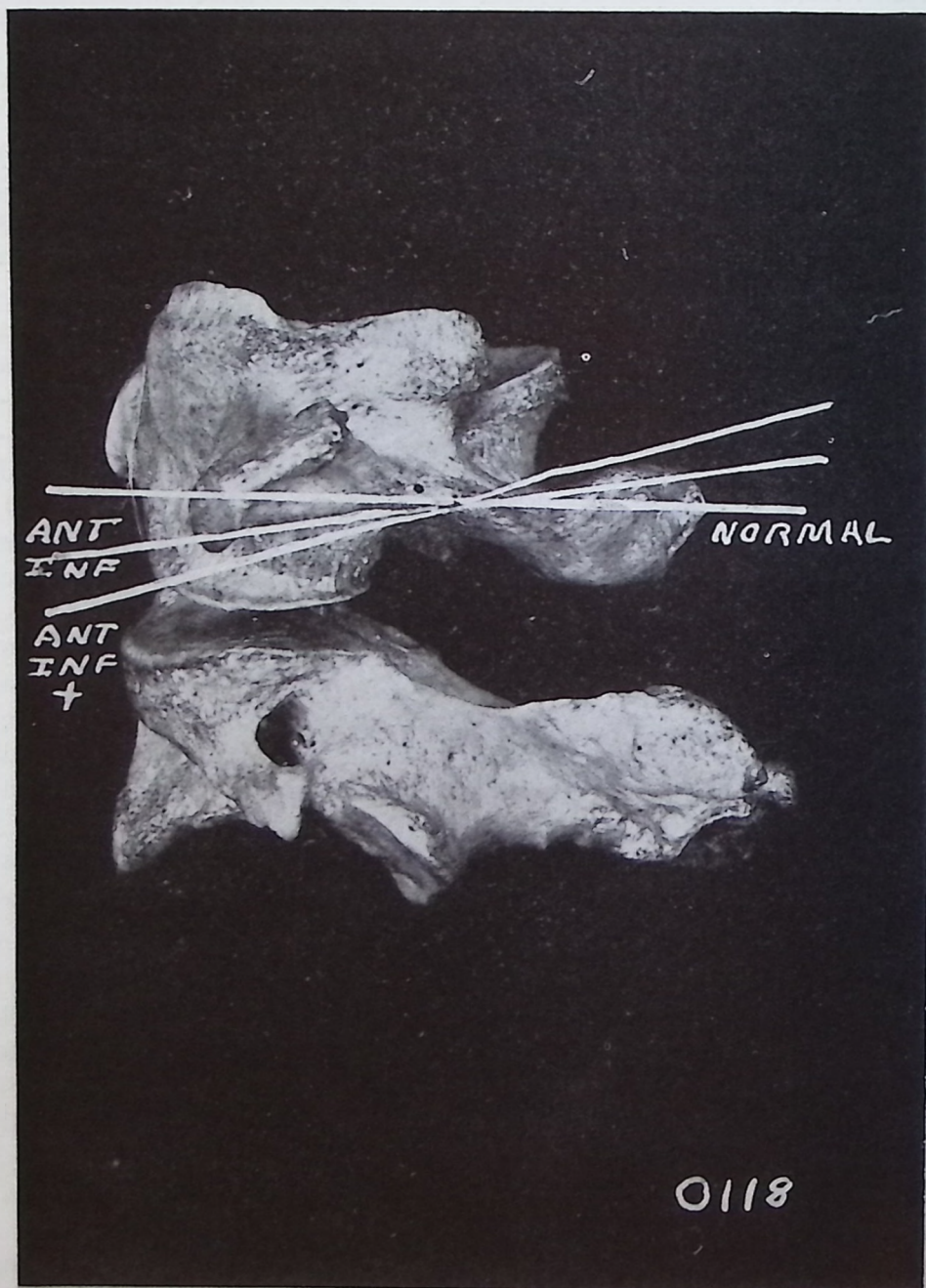


Illustration No. 118

trix structure, callous growth around spinal cord at point of friction of a vertebral hard substance against soft surrounding meninges of spinal cord, which in time GROWS to such a thickness that, concentrically builded like layers of an onion, it soon creates within itself A LOCAL PRESSURE because of the size of its own growth. A Chiropractor can accurately locate the abnormal position of the torqued subluxated hard osseous structure of the vertebra; he can just as accurately locate where the interference is. He can give an adjustment AND CORRECT THE ABNORMAL POSITION OF THE TORQUED SUBLUXATED HARD OSSEOUS STRUCTURE OF THE VERTEBRA, all of which may be done in a moment and the abnormal position of the torqued subluxated hard osseous structure of the vertebra DOES NOT NOW EXIST. The case, however, is a long way from being well. THERE IS STILL ANOTHER FORM OF PRESSURE TO BE REMOVED, viz., the concentrically builded growth of callous that is inside located BETWEEN bone and soft structure of spinal cord. This will need be torn down by Innate Intelligence. This may take weeks or months. MEANWHILE NO VERTEBRAL SUBLUXATION EXISTS. MEANWHILE A HARD SOFT TISSUE CALLOUS DOES EXIST. MEANWHILE AN ACTUAL INTERFERENCE DOES EXIST. It will continue to exist until such time as Innate Intelligence gradually and consistently tears it down, layer by layer, cell by cell; the length of time of which no Chiropractor knows.

If there is no osseous pressure and there is callous pressure with interference, what about readings made by callous interference with vertebral subluxation absent? If there is callous pressure, there is interference which WILL produce readings.

Illustrations 122 and 123.

Lateral view. Different plane lines; shows different degrees atlas can be superior. A-P view. Shows normal plane lines and and then the relative degrees to which it can be superior on right side.

Joining the lateral AND antero-posterior views, would mean an anterior, superior and right subluxation of atlas, in differing degrees with the differing methods of so expressing them.

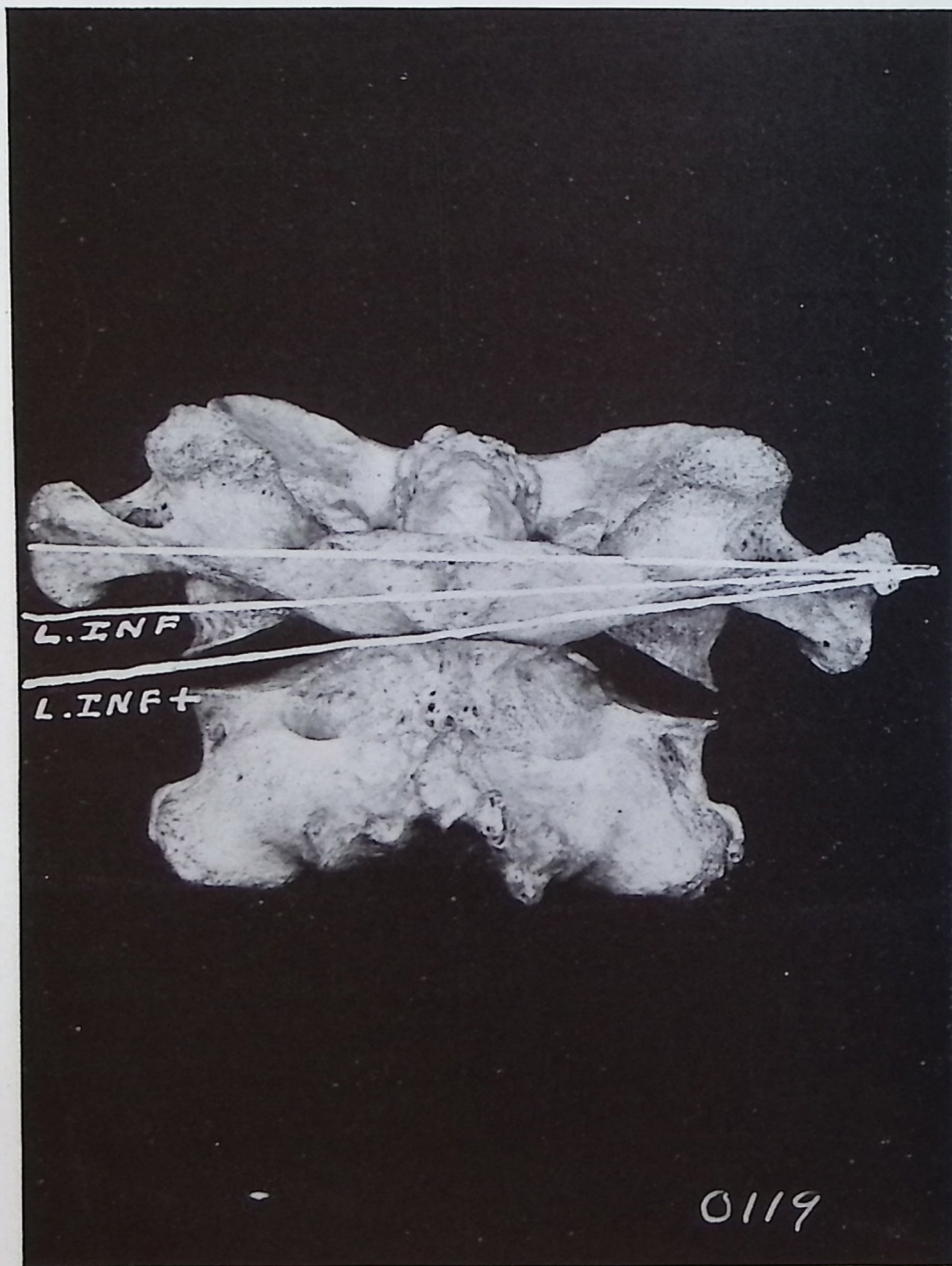


Illustration No. 119

Should an adjustment be given? If so, why? If there are readings, why not? How differentiate between callous interference heat reading and osseous vertebral subluxation interference heat reading?

The purpose of THIS book is not to enter into NCM technique or its problems, but a short explanation here is apropos.

When shoe-pressure rubs against toe-joint, shoe pressure as well as callous growth pressure exists against toe-joint. We now have dual pressure; 1st, of shoe; second, of callous. Remove shoe from foot, and you have removed shoe pressure; but you still have callous pressure. To remove shoe-pressure is to relieve THAT PORTION and THAT DEGREE of the complete number of pressure readings. Callous-pressure readings remain. If shoe is kept off foot, given time, callous-pressure will be dissolved and callous pressure will disappear entirely.

When vertebral subluxation pressure rubs against meninges, meningeal callous growth occurs, which creates subluxation pressure as well as callous pressure upon spinal cord. We now have dual-pressure: 1st, of vertebra; 2nd, of callous. Adjust vertebral subluxation and you have removed bone-pressure; but you still have callous pressure. To adjust subluxation is to correct

Illustrations 124 and 125.

In reading all spinographs, we do not determine which vertebra (atlas or axis) is subluxated by ONE view alone. We must have both A-P AND lateral. The same is true of these sets of photographs. This group illustrates the relative and comparative values of different degrees in which the vertebra can be subluxated; and a method of expressing that degree in terms which can be used by the Chiropractor in keeping his record or referring the case to some other Chiropractor.

Lateral view. Different plane lines; shows different degrees that atlas can be superior.

A-P view. Shows normal plane line and then the relative degrees to which it can be superior on left side.

Joining the lateral AND antero-posterior views, would mean an anterior, superior, left subluxation of atlas, in differing degrees.

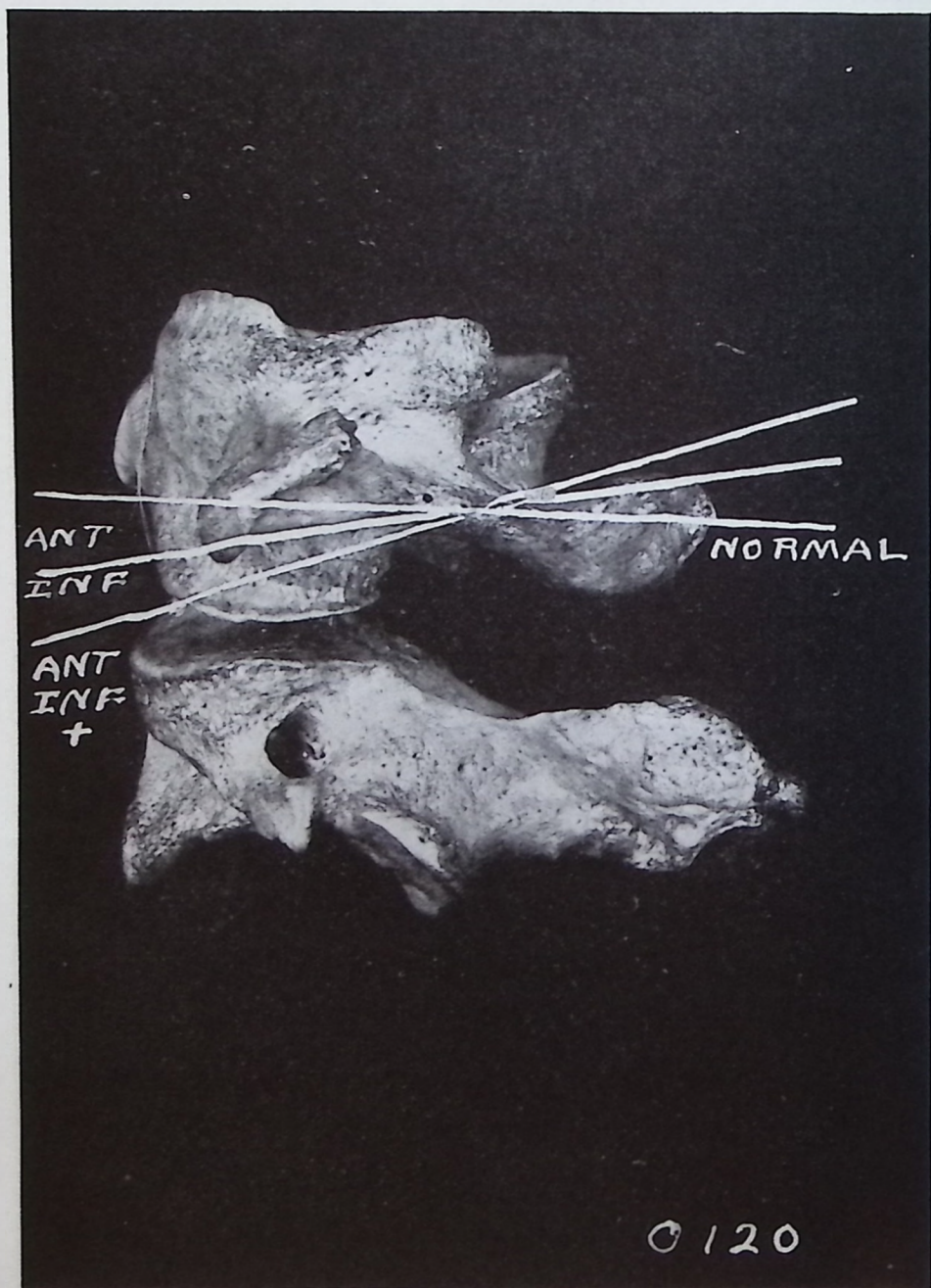


Illustration No. 120

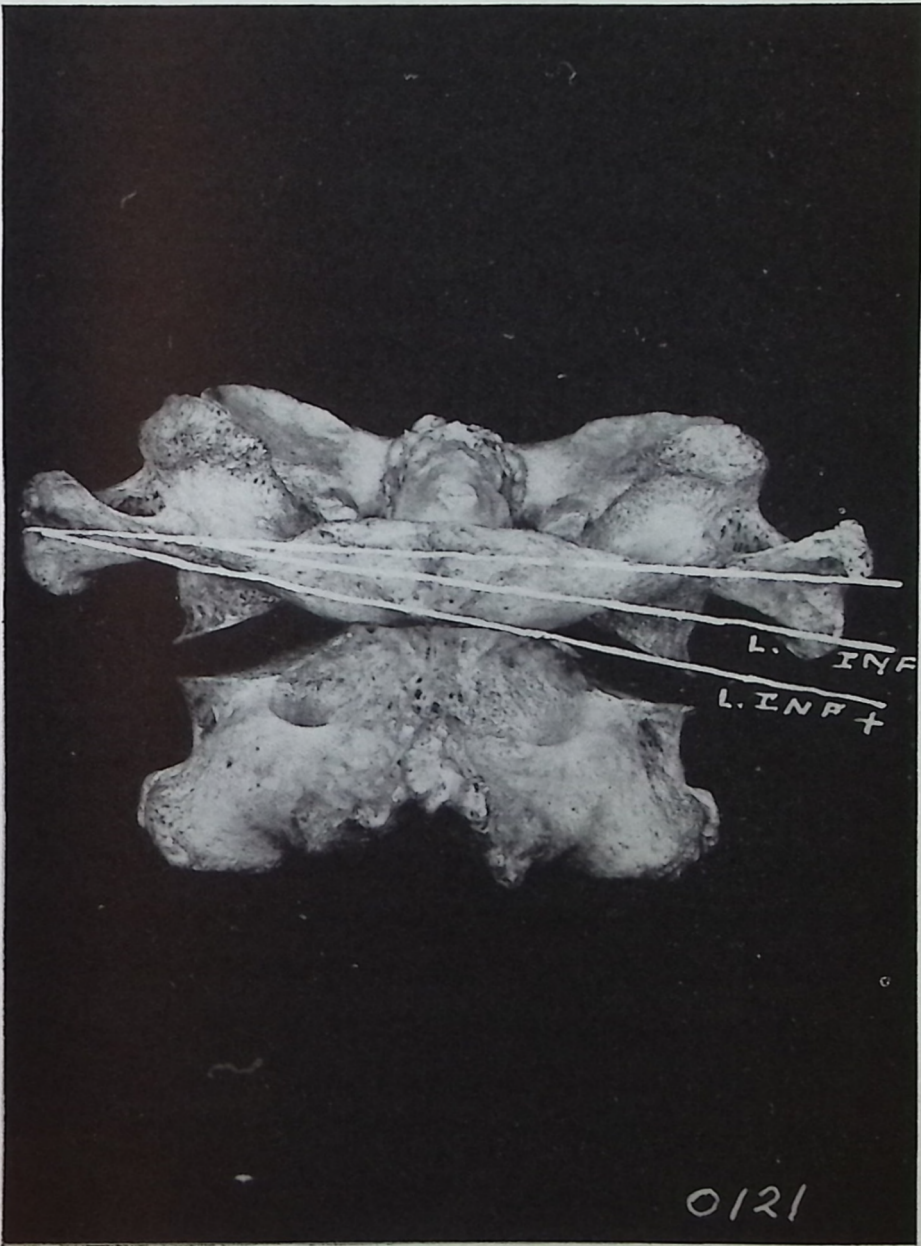


Illustration No. 121

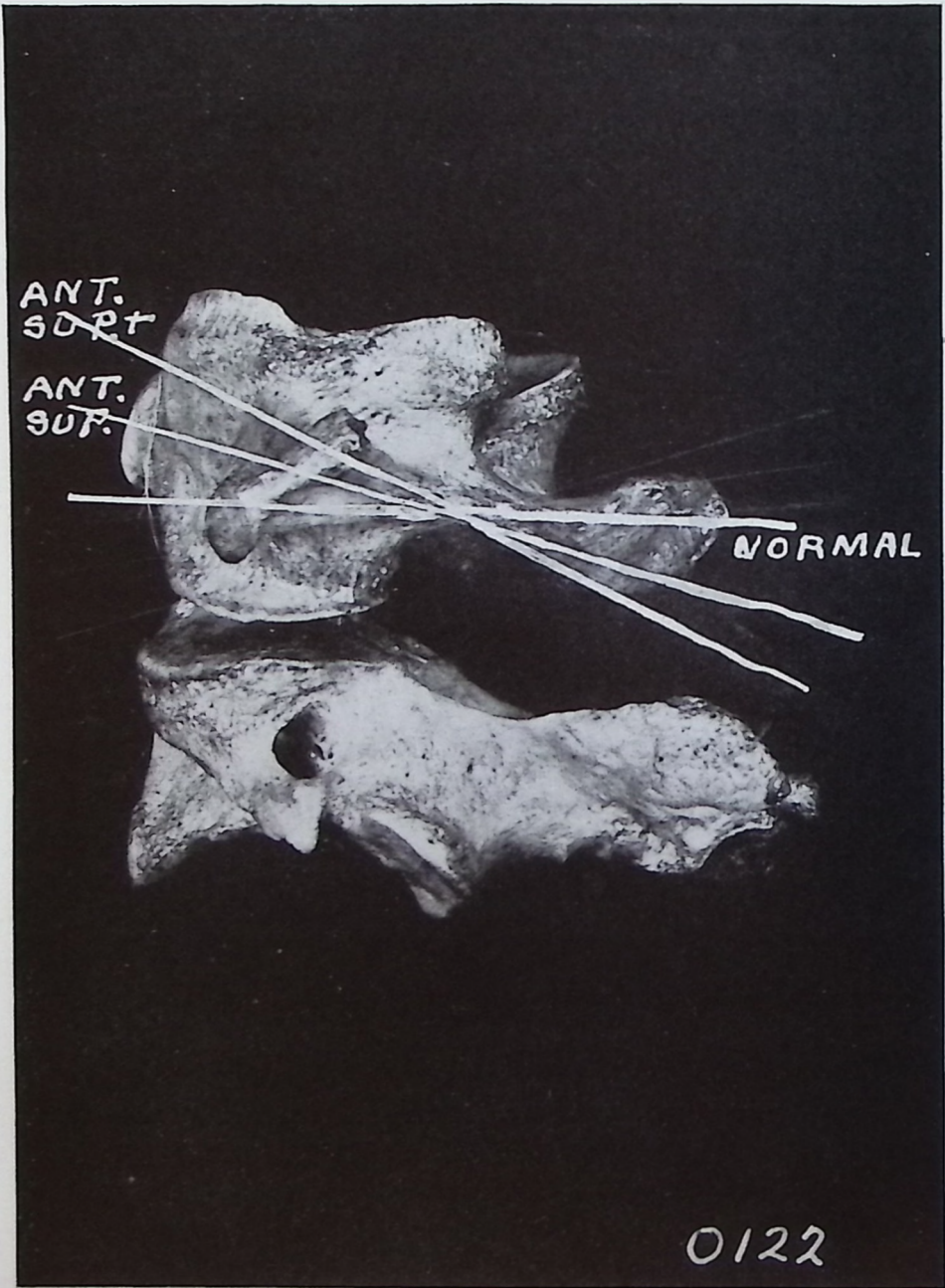


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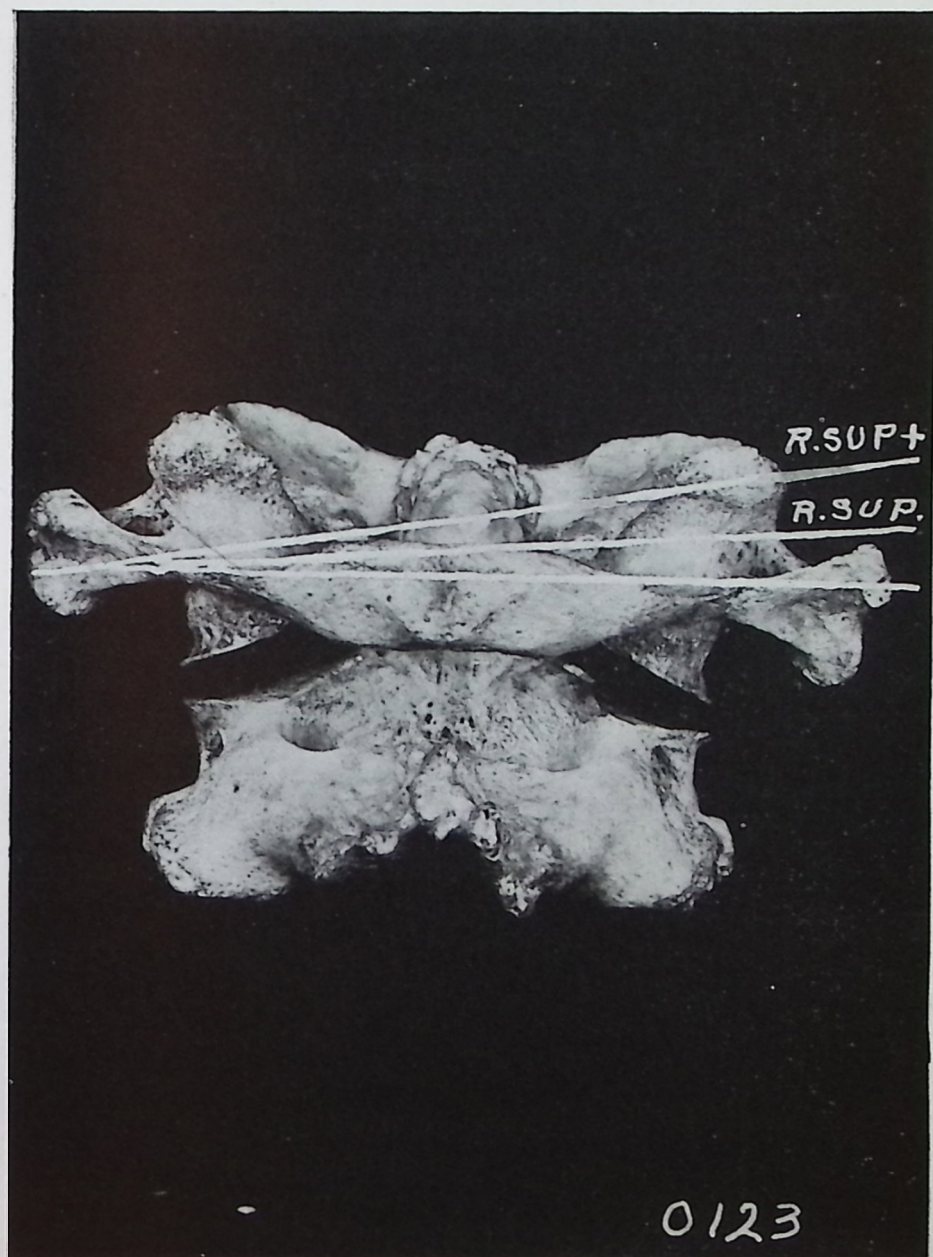


Illustration No. 123

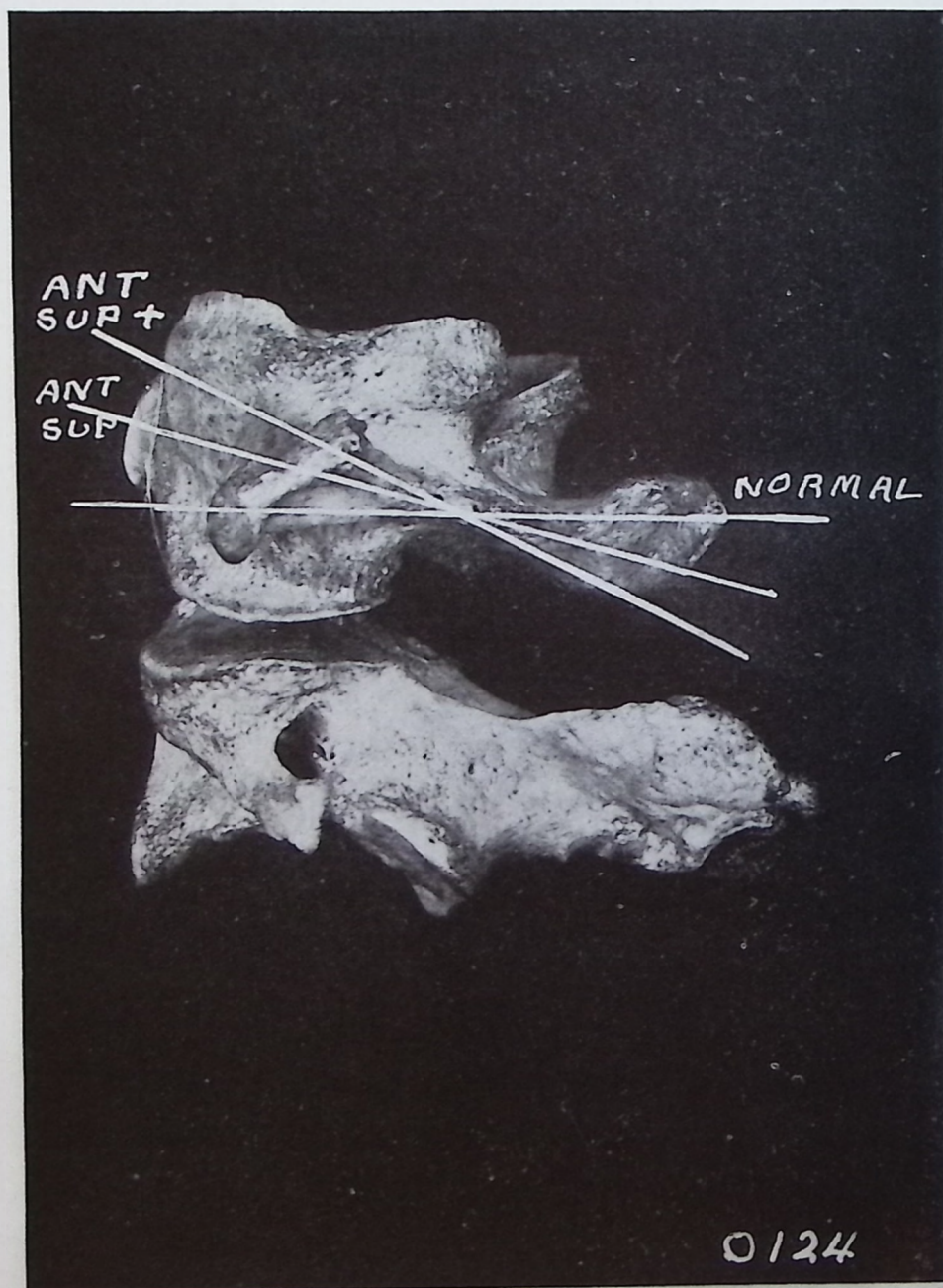


Illustration No. 124

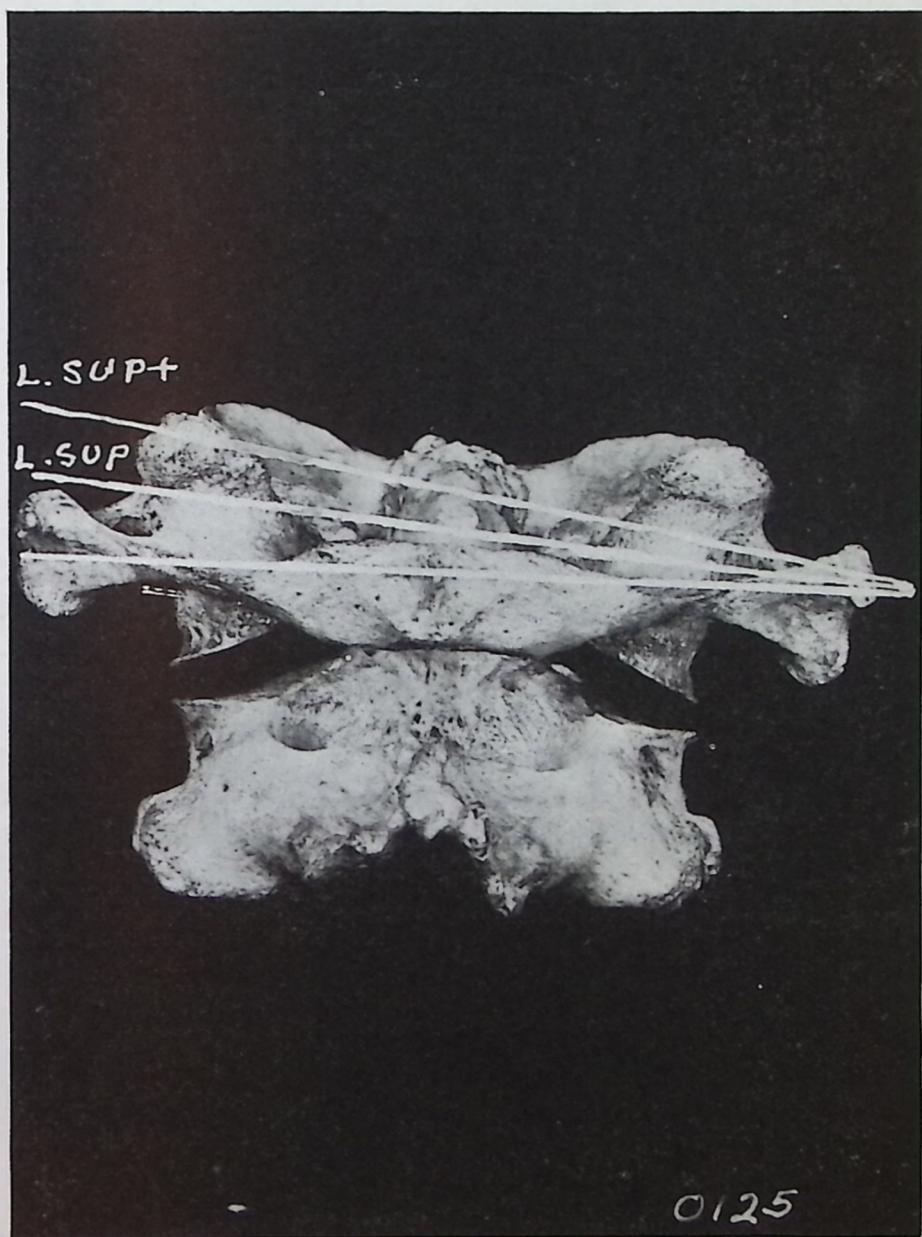


Illustration No. 125

THAT PORTION and THAT DEGREE of the complete number of pressure readings. Callous-pressure readings remain. If subluxation is kept corrected, given time, callous pressure will be dissolved and callous pressure will disappear entirely.

If there be vertebral subluxation, with occlusion, pressure and interference setting up pathology of spinal cord which induces shrinkage of spinal cord, it is obvious that even after adjustment of osseous pressure has been released, the normal quota of mental impulse supply cannot be transmitted until spinal cord grows back to normal size.

As soon as vertebral subluxation has been adjusted, SOME readings will be completely checked out; others will be partially checked out. Others will still be present and remain so for a while — time being indeterminate. This is evidence of accomplishing your objective. No vertebral adjustment will be needed again unless and until such sum total of original readings re-occur in the future. The return of those readings is evidence of return of osseous pressure and assures observation of necessity of another adjustment. Continued checking of case, assuming first check-outs remain, will prove callous checkings will gradually fade without further adjustment.

This is one salient reason why DAILY RECORDS and a constant daily checking with repeated analysis and study of records is vital, to know what is happening in case. The NCM makes this record possible.

Reiterating there are four possible kinds of "pressure" at occipital, atlas and axis region:

1. Osseous pressure—explained above.
2. Cicatrix pressure—explained above.
3. Meningeal torque twist.
4. Inflammatory pressure. Taking the latter and explaining it further, step by step, here is the analysis:
 - a. Concussion of forces
 - b. Vertebral torqued subluxation of atlas or axis
 - c. Interference to transmission
 - d. Resistance to transmission setting up inflammation of the meninges surrounding spinal cord in atlas, axis region

- e. Inflamed tissues swell, squeezing out to the limits of the canal; then squeezing inward upon the spinal cord. It is in this period that the 2nd kind of pressure becomes a physical reality. This period of inflammatory pressure may exist for several weeks or a month or two before it subsides from the acute to the chronic stage, as to degree and time. Certain types of pathologies manifest this prominently, particularly, anterior acute poliomyelitis or infantile paralysis.

5. Spinal cord shrinkage interference.

It behooves us to remember that the incipient or primary is the osseous mechanical pressure, to which all else are subsequent effects. When the primary is corrected, all effects correct themselves naturally.

Three vital osseous pressure questions enter this problem, at this place, at this time, in these ways:

1. The vertebral subluxation can be of—
 - occiput upon atlas
 - atlas upon occiput (in either event, atlas being adjusted)
 - atlas upon axis
 - axis upon atlas (in either event, either atlas or axis may be adjusted)
 - axis upon third (in either event, either atlas or axis would be adjusted)
2. The endless possibility of any small or large number of fibres being impinged, pressed upon. It could be 1,000, 1,000,000 more or less. Who knows?
3. The endless possibilities dormant, becoming active, in degree of pressure involving quantity of flow of mental impulse supply. It could be 1,000 fibres 100%. It could be one million fibres 1%. Who knows? Between the three potential possibilities, some specific location, some definite number of fibres, some positive quantity of interference exists; subject to some slight change within its subluxation area of motion from day to day, week to week.

How now should films be read! Take a lateral view. Study your contour lines. Follow that anterior curve, from below upward, clear thru to the skull; then somewhere along that line you will note a break in that contour; the kink, twist, wrench,

or torque will appear, making a more or less right angle distortion between some two of the mentioned vertebrae.

Take A-P views and do the same. Put them in the view-box, one by one. Do not sit close to them, but stand back. Instead of studying detail, give them a general-contour-once-over. Get a long-range perspective of the entire A-P occipital vertebral cervical lines. Gradually reduce the area until you reduce it to the region of the superior cervical vertebrae. Now take the lateral kink, twist, or torque of the lateral view and piece it together with the same kink, twist, or torque of the A-P view, as to the compound direction, and you will know EXACTLY how to direct the direction of adjustment with that extra something, with staying-put value. Read plates any other way, adjust them any other way, they will not stay. Read them THAT way, apply forces correctly in THAT light, and they will stay put; your readings will consistently check out and stay out.

In studying A-P views, clearly observe relations between occiput, atlas, and axis. Look for wedge of atlas, whether right or left, whether high or low on right, whether high or low on left; the seemingly abnormal position of occiput in relation to that of axis. Study opposing directions of occiput one way and atlas the other. Endeavor to see clearly (if it exists) lateral three-direction wedge-side-slip kink, torque, wrench, or twist of atlas between occiput above and axis below.

Lateral views show the anterior arch of atlas inferior or superior if axis and other inferior cervical vertebrae are in normal relationship. Lateral views may show spinous process of axis inferior if atlas is in normal relationship with occiput, but the KINK, TWIST, WRENCH, OR TORQUE is never MECHANICALLY found lower than that.

There are some certain few individuals who have extremely low occiputs, very large or long teeth, and possibly they cannot open wide their mouth. This makes it quite difficult to always get a good clear, unobstructed A to P spinograph of the Atlas and Axis. In this event it becomes necessary to take a third exposure from the anterior to the posterior, centering the tube over the nasal cavity; then, too, this type of film has often proven quite valuable as a matter of verification when deciding

the slightest wedge, or side slip as of the ordinary A to P cervical exposure.

There is always more or less doubt whether or not this slightest wedge is actually true, or whether it is the result of distortion caused by the angling rays, or, by misplacement of the patient on the table. However, all doubt seems to be obliterated when taking this third picture through the nasal cavity.

The patient is placed as for the regular A to P cervical picture, except the mouth is kept closed during the exposure. The chin is somewhat lowered so as the forehead will be on about the same plane as the body; centering the tube with the central rays directed downward over the Atlas and condyle articulations. Using intensifying screens and with Bucky Diaphragm, for the average individual 67 Kilovolt Peak, 20 seconds of time, 10 Milliampères, at 52 inch tube distance. With screen and not Bucky Diaphragm, 60 Kilovolt Peak, about 4 seconds, 50 Milliampères, with the same 52 inch tube distance.

CORRECT adjustment depends upon WHICH ONE is THE one making the kink, twist, or torque. If atlas is THE one making that kink, twist, wrench, or torque, then that is THE one to adjust to correct it. It is possible "to move" axis; it is possible to get TEMPORARY reductions in readings by "adjusting" axis; BUT NO ADJUSTMENT HAS EVER BEEN GIVEN UNTIL THE VERTEBRA WHICH WAS KINKED, TWISTED, WRENCHED, OR TORQUED INTO A SUBLUXATION IS ADJUSTED UNTIL IT NO LONGER IS A KINK, TWIST, WRENCH, OR TORQUE. If axis is THE one making that kink, twist, wrench, or torque, then that is THE one to adjust to correct it. It is possible "to move" atlas; it is possible to get TEMPORARY reductions in readings by "adjusting" atlas; BUT NO ADJUSTMENT HAS EVER BEEN GIVEN THAT WILL ATTAIN PERMANENT REDUCTIONS WITH PERMANENT RESTORATION, WITH PERMANENT SURVIVAL VALUE HEALTH, UNTIL THE VERTEBRA WHICH WAS KINKED, TWISTED, WRENCHED, OR TORQUED INTO A SUBLUXATION IS ADJUSTED UNTIL IT NO LONGER IS A KINK, TWIST, WRENCH, OR TORQUE.

A-P views show whether an atlas is left or right of its median line; whether left or right transverse is superior or inferior of

normal position. A-P views also show whether the spinous process of axis is left or right of median line. The lateral view shows whether it is inferior of its correct relationship with others above or below. It is the combined views of laterality and A-P which give combined twisted value of abnormal position.

(A few pages back, we mentioned what you would see on a Lateral view. We now mention what you will see on an A-P view. It might be well, at the close of your study of this Chapter, to refer back again to these two references; then go forward to an actual spinograph as illustrated in this book or as now set up in your view-boxes, and check items to better understand what we point out.)

It is folly for ANY person, and more so if he be a Chiropractor, to assume that HE CAN FEEL all this with his fingers, on outside of skin of patient. Even those of us most conversant with spinographic study of years, having studied hundreds of thousands of plates and films, have just seen, for the first time, what is here revealed. We could not have become conversant with this true finding now, had we not studied films. If WE find it necessary to have spinographic films to SEE this series of mal-positions, how could anyone assume that he need no films to feel the same? NO PERSON IS COMPETENT TO UNDERSTAND THE NATURE OF AND LOCATION OF THESE KINKS, TWISTS, WRENCHES, AND TORQUES, WITHOUT A SPINOGRAPHIC SERIES OF FILMS, PROPERLY, COMPETENTLY TAKEN AND HONESTLY READ. Somebody using fingers, palpating, could reach a finger-mental conclusion, give an "adjustment" and MIGHT ACCIDENTALLY get it right. Accidents do happen in the best as well as the worst of regulated families. When human life is at stake, no person can afford to assume that majority accident of failure risk.

This knowledge IS important. No human fingers can palpate it; no human sense can look upon the outside of the human flesh and see it inside. The SPGH is the NECESSARY aid to reveal what is necessary to see inside, that a Chiropractor may KNOW rather than guess the position of that kink. In no sense am I a salesman for the X-ray when I utter this truth. The principle and conditions themselves create the necessity for the instrument, without which we are helpless in the light of necessary information.

The new evolution of understanding of torqued subluxations

has practically eliminated necessity for palpation, as we used to know it, use it, and the purposes for which it was developed as one of our finest arts. (Notwithstanding science moves on, and by very process of achievement eliminates much of less value and adds much of more value, and for fear of misunderstanding, we want our readers to know that The Palmer School of Chiropractic continues to teach the subject fully and thoroly. As long as legislation has incorporated it, and State Board examinations require it, students are taught the subject as fully now as in former days.) We used to go up and down backs, in class, hours every day for months, to develop a keen tactile sense of detailed discriminatory feeling that we might mentally develop a differentiation between one vertebra and another; to accurately know every one of the 24 movable vertebrae; to determine the position of each one by comparison with ones above and below, to know which was or was not "subluxated." In those days we needed to count, by digital feeling, correctly, to know which was the 4th dorsal, C.P., K.P., etc.; to know which way a spinous process was listed, such as P or A, L or R, S or I, etc.

Now for change. The NCM ascertains WHERE and WHEN the interference is. No need of doubtful or mistaken palpation conclusions to reach THAT decision. The spinograph, with its A-P and lateral views, gives accurate and true information regarding direction of the torque subluxation. No need of doubtful or mistaken palpation conclusions to reach THAT decision. The area is definitely confined to the superior cervical region. No need of palpation up and down the balance of the spinal column to ascertain with seeming correctness the number thereof. We need palpate to locate an atlas transverse process; or an axis spinous process—and while MORE important now than before, it is comparatively easy, for the purpose of ascertaining the place of placement of the nail point of the nail hand, to untorque the torqued subluxation.

1. Read carefully and slowly, with NCM to LOCATE the interference.

(See Illustration No. 140 and study text accompanying. It proves necessity for care in detail.)

2. Spinograph the superior cervical vertebrae, both A-P AND lateral.
3. Read both A-P AND lateral views to ascertain direction of the kink, at location of interference.
4. Read films, both A-P AND lateral, to seek combined directional knowledge of subluxation that is in that kink, twist, wrench, or torque.
5. Each torque subluxation has THREE directions.
 Axis—low side—right or left—from A-P spinograph
 Pos., Sup. or Inf.—from lateral spinograph.
 Atlas—Ant.—superior or inferior—from lateral spinograph.
 Left or right—from A-P spinograph.
6. Apply adjustment at THE place, at THE time, in THE way that reverses that kink, twist, wrench, or torque.
7. Re-check, after adjustment, with NCM to determine whether reading has been checked out and transmission has been restored.

While I mention both A-P and lateral views, I suggest emphasis upon A-P views to ascertain wedge-side-slips of atlas and lateral views to ascertain the idea of what we mean by a KINK OR TWIST, until you are able to understand and see the wrench or torque in it. The kink, twist, wrench or torque is more obvious and easier to see from the lateral view. Once you gain the information in question, to a point where you KNOW that you see what you see when you are looking, you can take A-P views and see it as readily as you could on lateral views. In reading ANY case, ALWAYS have both A-P and lateral views. BOTH ARE NECESSARY to give CORRECT interpretation of three directional torque twists which always exist.

Two questions arise amongst a few of our research workers:

"Is it possible to have a vertebral subluxation of an axis or atlas, producing a torque, with an inter-magnum-atlas foramen or odontoid producing pressure upon spinal cord, with interference to transmission at that point, WITHOUT creating ANY reading, external to spinal column, at superior to atlas, inferior to atlas, superior to axis, or inferior to axis, because of a no-nerve distribution at that or those points; thereby having a

spinal cord pressure with no external-to-intervertebral-foramen reading possible?"

"If my means are limited and I cannot afford both NCM and X-ray, which would you advise me to get first, assuming that I can afford only one?"

These questions are linked into a common answer.

The FIVE elements essentially necessary for seeking information upon which to base an exclusive process of deduction, upon which to determine where and when to base adjustment action, are:

1. Misalignment with co-respondents above and below
5. WHEREIN THREE DIFFERENT ABNORMAL DIRECTIONS FROM ITS NORMAL POSITION ARE IN PERMANENT MISALIGNMENT
2. Occlusion of a foramen thru which nerves pass
3. Pressure upon nerves
4. Interference to transmission of mental impulse supply

The first THREE elements are determinable ONLY with spinographic films, both A-P and lateral. Palpation is NOT reliable, accurate, or efficient; neither does it lead to competent or honest conclusions.

The last TWO elements are determinable ONLY with use of NCM, correctly and carefully used. Symptomatology, pathology, histories and diagnostic instruments do not reveal when they are or are not present, or where.

Let us assume the facts two ways:

Dr. A determines he will secure an NCM first. Notwithstanding its cost is \$155 for a lease, he prefers this first. He takes a complete spinal reading first day. He locates all interferences. BELIEVING his major is "somewhere around about and up in superior neck," he PALPATES to get "some sort of an idea which one it is," and how he thinks "it is out of normal position." He determines "it might be Axis PLI." He adjusts, checks, finds he has raised the reading. He now "thinks it might be" Axis PRI. He adjusts, checks, finds he hasn't changed the readings. He now "tries atlas ASL." This might take some out. He tries again. Eventually he MAY find a way that "seems to reduce it." He "thinks he has now found the RIGHT direction." Has he? If he fishes long enough, he CAN determine, if he

keeps checking, until he DOES find THE way that gives a complete check-out.

The Spinograph never will reveal check-out. NCM can eventually reveal correct direction. There are elements of guessing both ways, but less with NCM.

Suppose he concludes there are no fibres emitting superior to atlas or axis; that pressure is upon the cord upon fibres which emit below, therefore there would be no possibility of a reading superior; and upon this hypothesis he determines to check daily and adjust WHEN THERE IS A READING, and follow his spinograph on other days when there ARE NO READINGS. This in itself IS A CONTRADICTION. If there ARE readings some days, then it is proof there ARE readings. If, other days, there ARE NO READINGS, then it is proof that there ARE NO READINGS. (See what you see when you see it.) If he adjusts when there ARE readings, and follows spinographic listings for adjustments when THERE ARE NO READINGS, he is assuming that some days nerves ARE there and other days they are not. He contradicts two series of elements which are in part unto each other. If he followed the complete set-up as in our first question, working on the hypothesis that there NEVER ARE nerves there, and he thereby is compelled to follow spinographic listings at all times, he will immediately run into the answer of the second question and will over-adjust his case into a dangerous condition.

Dr. B. determines he will secure an X-ray first. Notwithstanding its cost is somewhere between \$1,000 and \$2,000 for complete installation, he prefers to secure this first. He takes spinographs, and they DO reveal the first three items or elements of information. These are necessary to have. He adjusts according to positions which they reveal. Has he given an adjustment? Has he released pressure? Has he permitted a restoration of transmission? He has NO WAY OF KNOWING. Suppose, desiring to check, he takes new spinographs DAILY, before each "adjustment," desiring to SEE if what he adjusted yesterday is still there today? Each day he spinographs anew. He finds vertebra in same torqued position. SEEING what IS revealed, he concludes he did NOT give an adjustment yesterday; so he gives an "adjustment" today. If he keeps up THIS process, spino-

graphing daily and adjusting according to what HE SEES daily, for a month, he will find his case is NOT gaining ground; on reverse, is losing. He is OVERADJUSTING. He is "adjusting" at times when it is NOT needed. He is "adjusting" at places when it should be left alone. If he follows this "process of deduction" logically, thru to its limit, he will be compelled to "adjust" EVERY PLACE in the spinal column where a torqued misalignment APPEARS to exist, not knowing whether they were or were not checked out as the result of AN ADJUSTMENT at any one superior place. Great harm CAN be done this way.

If a person MUST err, I would rather err on the under-side of under-doing; following NCM and adjusting only when readings DO appear.

(See enlarged study of this question, under heading, "Adjusting" and "Adjusting Technique of Torqued Subluxations of Atlas and Axis," Chapter XI.)

CHAPTER X.

VERTEBRAL TORQUE PECULIARITIES

ATLAS WEDGE-SIDE-SLIP SUBLUXATIONS



CCIPUT and atlas are locked in those articulations with each other, whereby condyles in convexity, with atlas in concavity cannot become subluxated, in either left or right articulations, either anterior or posterior, without atlas becoming a dislocation. Atlas is NOT locked in articulations with occiput, in right or left direction, which can become subluxated as a left or right wedge side-slip on both articulations, without becoming a dislocation. Normal articulation consists in flexion and counter-flexion in their cradles, in rocking chair forward and backward motion.

Atlas is locked from going posterior from occiput above because of concavity of articulations with convexity of condyles and is locked from going POSTERIOR from axis below because of fovea dentalis of anterior arch against odontoid process of axis. Atlas is NOT locked from being subluxated ANTERIOR from axis below because transverse ligament does not lock this abnormal movement as shown in spinographs.

Axis is locked from going anterior from atlas because of odontoid process of axis locking against fovea dentalis of anterior arch of atlas. Axis is NOT locked from going INFERIOR compressing spinous processes with cervical vertebrae below, bringing odontoid process of axis POSTERIOR into neural canal because transverse ligament does not lock this abnormal movement as shown in spinographs.

There are three general directions occiput, atlas, and axis CANNOT become subluxated, because of locks which prevent:

1. Atlas cannot subluxate anterior or posterior off of condyles
2. Atlas cannot subluxate posterior because of odontoid process
3. Axis cannot subluxate anterior because of fovea dentalis.

There are three general directions occiput, atlas, and axis CAN become subluxated, because there are no locks to prevent:

1. Atlas side-slips to right or left; indicated by R or L, HI or LO
2. Atlas. Anterior arch, S or I; indicated by AS or AI

3. Axis. Spinous process inferior; spinous process to R or L of median plumb line; odontoid process posterior; indicated by PRI or PLI, True or False.

That which is most difficult to understand and which presents the most complexing confusion, in presenting atlas wedge-side-slip subluxation, is in apparent contradictions, as follows:

- when head is high (or low) or right (or left)
- when atlas has side-slipped to right (or left)
- when occiput is low on right (or left)
- when occiput is high on left (or right)
- then it is a right (or left) high (or low).

Occipital condyles form a forward or backward rocking-chair dual-joint articulation. Longitudinal axis is anterior-posterior. They draw together on anterior and separate on posterior. They slant obliquely laterally and flare outward. They are convex from anterior to posterior.

Superior articular facets of atlas form a forward and backward rocking-chair dual-joint articulation, in every respect exactly opposite to those of occiput. Longitudinal axis is anterior-posterior. They draw together on anterior and separate on posterior. They slant obliquely internally and flare superior toward the median line of the body. They are concave from anterior to superior.

Put the two together, side-slip atlas to right off of occipital condyles, and you find that as atlas slips to right

- right atlas articulation slips to right and superior
- right occipital articulation appears to slip to left and inferior
- left atlas articulation slips to right and inferior
- left occipital articulation appears to slip to left and superior
- and as atlas slips to left

- left atlas articulation slips to left and superior
- left occipital articulation appears to slip to right and inferior
- right atlas articulation slips to left and inferior
- right occipital articulation appears to slip to right and superior.

This peculiar mechanical joint (between occiput and atlas) will not allow for slipping of one side of atlas to anterior in its relation with occipital condyles without opposite side slipping to anterior to approximately same degree.

Atlas can move laterally BETWEEN occipital condyles above and axis below, WEDGING between them to left or right. When it is right or left in relation with occipital condyles, articular facet of atlas will be slightly higher on occipital condyle on side of laterality, and low to approximately same degree on side opposite laterality.

Lateral mal-position of articular facets of atlas on occipital condyles will cause plane line of occiput to be lower, in relation with plane line of atlas on side of laterality and higher in relation to plane line of atlas on side opposite laterality.

(Plane lines for studying wedge-side-slip subluxations of atlas will be found under Chapter XXVIII. After studying this Chapter turn to that and link two lines of facts together.)

In this description we have two views: an A-P in which there is a left or right "superior" and "inferior"; a lateral in which there is an anterior arch which can be "superior" and "inferior." To use these terms interwovenly between A-P and lateral views would be confusing, and you wouldn't know what the writer was talking about, or to which he was referring. To clarify and make a more direct application, we have seen fit to apply terms "high" and "low", meaning that as we looked at a spinograph from rear (A-P view) head would be "high" or "low" on one side or other. Looking at a spinograph from lateral, anterior arch of atlas could be "superior" or "inferior." The atlas might be "HIGH" on one side (A-P view) and could be INFERIOR on ANTERIOR arch on a lateral view. The atlas might also be "LOW" on one side (A-P view) and could be SUPERIOR on ANTERIOR arch on a lateral view.

Lateral views of spinographs, between occiput, atlas, and axis, show contrast between positions of posterior and anterior arches of atlas, in a large majority of cases. If anterior arch of atlas is superior, posterior arch is inferior and vice versa. To have an anterior arch SUPERIOR it must rock ANTERIOR on its cradles. In this position it shifts position of axis so that superior tip of axis odontoid process slopes obliquely upward and forward. To have an anterior arch INFERIOR it must rock POSTERIOR on its cradles. In this position it shifts position of axis so that inferior tip of axis odontoid process slopes obliquely upward and backward. We have said that the ONLY direction atlas CAN

subluxate is ANTERIOR from odontoid process of axis. Here is a seeming exception, notwithstanding comparative position of odontoid makes it still true. All listings of atlas are made from comparative position of ANTERIOR ARCH as to whether IT is superior or inferior.

The basis of determining wedge-side-slip atlas subluxation is that it be a lateral side-slip creating wedge between itself and occiput above and axis below. If this condition does NOT exist, then it does not possess the distinctive feature of an atlas wedge-side-slip. When A-P spinograph view of cervical region does not show left or right, high or low, wedge-side-slip, and lateral spinograph view of cervical region does show anterior arch superior or inferior, would atlas be chosen as THE subluxation in preference to axis? Answer is "No!" Primary necessity for atlas subluxation is that it MUST be, on A-P view, a lateral wedge-side-slip. That being absent, even tho on lateral view anterior arch is superior or inferior, atlas rule would be ignored, especially when on A-P view plane lines are parallel and do NOT prove existence of wedge-side-slip.

(See further explanation under Definitions.)

In exaggerated wedge-side-slips, the eye can see plane levels of occiput, atlas; recognize existence of wedge, etc. Gradually as wedge-side-slip diminishes in severity, it becomes difficult to be certain. Many people SEE level and plumb lines with their eyes, accurately. Others need rules, calipers, measuring devices to correct incorrect lines of human vision.

In measuring wedge-side-slip atlas subluxations, there are various points and places on atlas and occiput which can be used:

Atlas land-marks:

1. Lateral inferior tips of lateral masses
2. Internal inferior tips of lateral masses
3. Junction between transverse process and lateral masses, on each side, drawing a line thru from side to side, extending it out to a point inferior to two occipital jugular process tips superior to it.
4. Possibly superior lateral tips of axis pre-zygapophyses in some instances.

Occipital land-marks:

If observable (and usually they are) the occipital jugular process tips.

Difficulty in establishing land marks on atlas and occiput is inability to shoot X-ray thru teeth level. Average head, in normal, natural position, will bring teeth line on an approximate level with base of skull, hide condyles, and oftentimes crowd portions of atlas in behind teeth shadows. This could be avoided by throwing head backward, raise superior teeth above condyle level, and when you do, you strain head into a FORCED position and you DON'T GET natural position location of subluxation.

Either way you face a problem. First, if you throw head backward in order to raise teeth level above condyles, to bring condyles and superior portion of atlas into picture clearly, you present a forced position and don't get true reading. Second, if head is carried in natural position for location, teeth hide condyles and superior portion of atlas, and obliterate possible land-marks. Either evil is bad, but of the two strained, forced position would be more dangerous.

Sometimes, but not always, there is overlapping of atlas inferior articulations in relation to superior articulations of axis. The side-slip off articulations is objective. This is not absolute. Frequently adaptation takes place where axis follows thru with atlas in a side-slip. Sometimes there is discrepancy in relation of odontoid process in fovea dentalis with axis, which may be left or right of median center in fossa with atlas, regardless of whether it be a high or low, on either side. Adaptation sometimes takes place here also.

We refer to "occiput APPARENTLY is, or APPEARS to be", meaning that occiput does not actually MOVE to position suggested. It is ATLAS WHICH HAS MOVED BETWEEN occiput and axis.

Occiput moves NORMALLY only ONE way upon atlas: forward and backward—the rocking chair motion. Atlas moves ABNORMALLY THREE WAYS between occiput above and axis below:

- a. Forward and backward
- b. left to right; right to left, lateral
- c. anterior arch to anterior superior, or anterior inferior.

Atlas and axis subluxations are divisible into three groups. Sometimes, to try to divide that which has a difference is difficult. It may be even more difficult to be able to prove difference in application to cases.

- (a) wedge-side-slip subluxation of atlas
- (b) subluxation of atlas without wedge-side-slip
- (c) subluxation of axis.

The difference between first (a) and second (b) group of atlas subluxations will be described now in detail. The object of listing three groups is to describe and emphasize the "a" group.

I call this a WEDGE-SIDE-SLIP subluxation; or it might be called a REVERSED-SIDE-SLIP, because

- (a) atlas is a WEDGE between occiput above and axis below.
A wedge is thin on its entering edge and thicker at the opposite end, and that is exactly what happens in a wedge-side-slip atlas subluxation. The thin edge is always on the lateral side the atlas slips TO.
- (b) it is a SIDE-SLIP because atlas does slip to one side BETWEEN occiput above and axis below.
- (c) it REVERSES directions:
 - when atlas slips right, occiput appears left on atlas
 - when atlas slips left, occiput appears right on atlas
 - when atlas slips high on right (A-P view) occiput appears left on atlas.
 - when atlas slips high on left (A-P view) occiput appears right on atlas.
 - when head is high on right and atlas has slipped high on right, head appears high on right, low on left; occiput appears low on right, high on left.
 - when head is high on left and atlas has slipped high on left, head appears high on left, low on right; occiput appears low on left, high on right.
 - when head is low on right and atlas has slipped high on right, head appears low on right, high on left; occiput appears low on right, high on left.
 - when head is low on left and atlas has slipped high on left, head appears low on left, high on right; occiput appears low on left, high on right.

1. atlas to right, head high
 2. atlas left, head high
 3. atlas right, head low
 4. atlas left, head low
-

1. atlas to right, head high on right
 2. atlas to left, head high on left
 3. atlas to right, head low on right
 4. atlas to left, head low on left.
-

1. atlas to right, head high on right, occiput to left
 2. atlas to left, head high on left, occiput to right
 3. atlas to right, head low on right, occiput to left
 4. atlas to left, head low on left, occiput to right.
-

1. atlas to right, head high on right, occiput to left, occiput low on right.
 2. atlas to left, head high on left, occiput to right, occiput low on left.
 3. atlas to right, head low on right, occiput to right, occiput low on right.
 4. atlas to left, head low on left, occiput to right, occiput low on left.
-

1. atlas to right, head high on right, occiput to left, occiput low on right, occiput high on left.
 2. atlas to left, head high on left, occiput to right, occiput low on left, occiput high on right.
 3. atlas to right, head low on right, occiput to right, occiput low on right, occiput high on left.
 4. atlas to left, head low on left, occiput to right, occiput low on left, occiput high on right.
-

Put 1's together and you have one kind of an atlas wedge-side-slip subluxation. Put each of the other numbers together and you have the other three—there being but four kinds.

When HEAD is high on right lateral (A-P view)
OCCIPUT appears low on right lateral

ATLAS is high on right lateral (note seeming contradiction of these terms)

ATLAS is lateral TO right.

If, in addition to above, atlas was (lateral view) anterior superior, it would be a three-directioned, torqued, locked subluxation. We would call this a "right high side-slip atlas." It would be listed as "ASR wedge-side-slip subluxation of atlas."

If, in addition to above, atlas was (lateral view) anterior inferior, it would be a three-directioned, torqued, locked subluxation. It would be listed as "AIR wedge-side-slip subluxation of atlas."

Adjustment would be on right transverse process of atlas, from ASR or AIR. According to A-P view it was superior on right, and on lateral view it was AS or AI.

There is one element introduced in above which will appear confusing to those who have taken our early torque work, that differs from atlas work which follows later in this Chapter. That element which seems contradictory is:

Where HEAD is HIGH ON RIGHT (A-P view)

Where OCCIPUT appears LOW ON RIGHT (A-P view)

How can a HEAD be HIGH on right with an OCCIPUT appearing LOW on right? When atlas is subluxated high on right, it can raise head on right with it. Head remains high so long as atlas subluxation is high on right lateral. As atlas wedge-side-slips TO RIGHT high, it permits occiput to appear to wedge-side-slip TO LEFT. The degree that head is high on right is much greater than the degree that occiput is apparently low on right. As atlas wedge-side-slips to right and high, and occiput appears to side-slip to left, it permits occiput to appear to drop low on its atlas right superior articulation and appears to raise occiput on its left atlas superior articulation. This condition of atlas being right and high keeps HEAD MORE HIGH on right, but brings about a closer approximation (if measured) between right lateral mass of atlas and occiput on right and separates the distance (if measured) between left lateral mass of atlas and occiput.

The first group of atlas subluxations are listed and adjusted same as the second group which follow later in this Chapter, with the exception that there is no known existence of wedge-side-slip

of atlas in second group as described, viz., as in second group atlas subluxates superior on right, head and axis would be carried with it without apparent dropping of occiput on high side.

(We present pen and ink sketch illustrating this right high wedge-side-slip atlas subluxation idea. We have purposely exaggerated its position to clarify. It will not be found so amplified in reality in spinographs. See Illustration No. 60.)

When HEAD is high on left lateral (A-P view)

OCCIPUT appears low on left lateral

ATLAS is high on left lateral (note seeming contradiction of these terms)

ATLAS is lateral TO left.

If, in addition to the above, atlas was (lateral view) anterior superior, it would be a three-directioned, torqued, locked subluxation. We would call this a Left High Side-Slip Atlas. It would be listed as "ASL wedge-side-slip subluxation of atlas."

If, in addition to the above, atlas was (lateral view) anterior inferior, it would be a three-directioned, torqued, locked subluxation. It would be listed as "AIL wedge-side-slip subluxation of atlas."

Adjustment would be on left transverse process of atlas, from ASL or AIL. According to A-P view, it was high on left and on lateral view it was AS or AI.

The same element of confusion might enter here, in contrast, viz.,

when HEAD is HIGH ON LEFT (A-P view)

when OCCIPUT appears LOW ON LEFT (A-P view)

How can a HEAD be HIGH on left with an OCCIPUT appearing LOW on left? When atlas is subluxated high on left, it can raise head on left with it. When atlas is high on left, head would be high on left, but as atlas wedge-side-slips TO left, it permits occiput to appear to side-slip TO right. The degree that head is high on left is much greater than the degree that occiput is apparently low to right. As atlas wedge-side-slips left high, and occiput appears to wedge-side-slip to right, it permits occiput to appear to drop low on atlas superior left articulation and also appears to raise occiput on its right atlas superior articulation. This condition of atlas being left and high keeps

HEAD MORE high on left but brings a closer approximation (if measured) between left lateral mass of atlas and occiput on left, and separates the distance (if measured) between right lateral mass of atlas and right occiput. The wedge-side-slip brings lateral mass and occiput together on left high side and separates them on atlas low right side. Given a certain place on left lateral mass and a given place on occiput just above, measure it and you will find it LESS on high side than on low side. It is that closer approximation between lateral mass on high side and occiput that makes "occiput appear low" on high side.

(We present pen and ink sketch illustrating this left high wedge-side-slip atlas subluxation idea. We have purposely exaggerated its position to clarify. It will not be found so amplified in reality in spinographs. See Illustration No. 61.)

When HEAD is high on right lateral; low on left lateral (A-P view)

OCCIPUT appears high on right lateral; low on left lateral

ATLAS is low on right lateral; high on left lateral (note seeming contradiction of terms)

ATLAS is wedge-side-slip lateral to left.

If, in addition to the above, atlas was (lateral view) anterior superior, it would be a three-directioned, torqued, locked subluxation. We would call this a left low side-slip atlas. It would be listed as "ASL wedge-side-slip subluxation of atlas."

If, in addition to the above, atlas was (lateral view) anterior inferior, it would be a three-directioned, torqued, locked subluxation. It would be listed as "AIL wedge-side-slip subluxation of atlas."

Adjustment would be on left transverse process of atlas, from ASL or AIL. According to A-P view it was high on right, low on left; and on lateral view it was AS or AI.

The difference here, between this wedge-side-slip atlas subluxation and the first, is that the atlas has side-slipped to left WHICH IS THE LOW HEAD SIDE. The head appears to wedge-side-slip to right WHICH IS THE HIGH HEAD SIDE.

Even tho HEAD is low on left lateral

OCCIPUT appears low on left lateral

ATLAS has side-slipped TO LEFT, raising left of atlas and lowering right of atlas

Measured distance between lateral mass and occiput ON LEFT is less

Measured distance between lateral mass of atlas and occiput ON RIGHT is more.

Atlas can side-slip to LOW head side as readily and as easily as it could to HIGH head side.

(We present pen and ink sketch illustrating this left low wedge-side-slip atlas subluxation idea. We have purposely exaggerated its position to clarify. It will not be found so amplified in reality in spinographs. See Illustration No. 62.)

When HEAD is high on left lateral; low on right lateral (A-P view)

OCCIPUT appears high on left lateral; low on right lateral

ATLAS is low on left lateral; high on right lateral (note seeming contradiction of terms)

ATLAS is wedge-side-slip lateral to right.

If, in addition to the above, atlas was (lateral view) anterior superior, it would be a three-directioned, torqued, locked subluxation. We would call this a right low side-slip atlas. It would be listed as "ASR wedge-side-slip subluxation of atlas."

If, in addition to the above, atlas was (lateral view) anterior inferior, it would be a three-directioned, torqued, locked subluxation. It would be listed as an "AIR wedge-side-slip subluxation of atlas."

The difference here, between this wedge-side-slip atlas subluxation and the second is that the atlas has side-slipped to right WHICH IS THE LOW HEAD SIDE. The occiput appears to wedge-side-slip to left WHICH IS THE HIGH HEAD SIDE.

Even tho HEAD is low on right lateral (A-P view)

ATLAS has side-slipped TO RIGHT, raising right of atlas and lowering left of atlas

Measured distance between lateral mass and occiput ON RIGHT is less

Measured distance between lateral mass and occiput ON LEFT is more.

Atlas can side-slip to LOW head side as readily and as easily as it could to HIGH head side.

The determining factor, on all side-slip atlas subluxations, is to determine WHERE THE COMPRESSION EXISTS BETWEEN ATLAS AND OCCIPUT; to which side it is SQUEEZING EACH OTHER CLOSER.

(We present pen and ink sketch illustrating this right low wedge-side-slip atlas subluxation idea. We have purposely exaggerated its position to clarify. It will not be found so amplified in reality in spinographs. See Illustration No. 63.)

In this particular type of atlas subluxation (wedge-side-slip),
—the torqued right high (A-P view) subluxation of the atlas throws HEAD high on right side, but appears to side-slip occiput to left and low on right side, to left and high on left side.

—the torqued right low (A-P view) subluxation of atlas throws HEAD high on left side, but appears to side-slip occiput to left and high on left side, to right and low on right side.

—the torqued left high (A-P view) subluxation of atlas throws HEAD high on left side, but appears to side-slip occiput to right and low on left side, to right and high on right side.

—the torqued left low (A-P view) subluxation of atlas throws HEAD low on left side, but appears to side-slip occiput to right and low on left side, to right and high on right side.

If atlas is subluxated to RIGHT HIGH between occiput and axis, it appears to throw RIGHT condyle of occiput low and TO LEFT, the LEFT condyle of occiput appearing high ON left.

If atlas is subluxated LEFT HIGH between occiput and axis, it appears to throw LEFT condyle of occiput low and TO RIGHT, the RIGHT condyle of occiput appearing high ON right.

If atlas is subluxated LEFT LOW between occiput and axis, it appears to throw LEFT condyle of occiput LOW and TO RIGHT, the RIGHT condyle of occiput appearing high on right.

If atlas is subluxated RIGHT LOW, between occiput and axis, it appears to throw RIGHT condyle of occiput LOW and TO LEFT, the LEFT condyle of occiput appearing high on left.

Stating it another way: If atlas wedge-side-slips one way, occiput appears to wedge-side-slip to opposite way. These oppos-

ing different directions of atlas AND occiput appear to lower occiput on side that atlas is raised upon.

Condyles of occiput appear to slightly wedge-side-slip in opposite directions, off superior articulations with atlas. If atlas wedge-side-slips to right high, then right occiput condyle appears to wedge-side-slip to left and low on right articulation with atlas, and left occiput condyle appears to wedge-side-slip to left and high on left articulation with atlas.

If atlas wedge-side-slips to left high, then left occiput condyle appears to wedge-side-slip to right and low on left articulation with atlas. If atlas wedge-side-slips to left high, then right occiput condyle appears to wedge-side-slip to right and low on left articulation with atlas, and right occiput condyle appears to wedge-side-slip to right and high on right articulation with atlas.

The wedge-side-slip atlas subluxation differentiates it from another group of atlas subluxations, and helps to make possible a more accurate method of determining whether it is atlas or axis. The manner of interpreting spinographs is slightly different for a wedge-side-slip subluxation than for the usually accepted type. This wedge-side-slip differentiation peculiarity is observable only on A-P views. The lateral views of a wedge-side-slip would appear the same as any other atlas subluxation.

To read spinographs containing a wedge-side-slip atlas subluxation, I suggest you observe:

1st. On which side (A-P view) atlas is closer to occiput (both of which will be found on SAME side).

2nd. Lateral view will show whether anterior arch of atlas is superior OR inferior on lateral side.

Right (R) high (A-P view) in conjunction with
Anterior-Superior (AS) anterior arch of atlas (lateral view)
Is an ASR atlas listing.
Adjustment on right (R) transverse process to PIL
Spoken of as: RIGHT HIGH SUPERIOR SIDE SLIP.

Right (R) high (A-P view) in conjunction with
Anterior-Inferior (AI) anterior arch of atlas (lateral view)
Is an AIR atlas listing.

Adjustment on right (R) transverse process to PSL.
Spoken of as: RIGHT HIGH INFERIOR SIDE SLIP.

Right (R) low (A-P view) in conjunction with
Anterior-Superior (AS) anterior arch of atlas (lateral view)
Is an ASR atlas listing.

Adjustment on right (R) transverse process to PIL.
Spoken of as: RIGHT LOW SUPERIOR SIDE SLIP.

Right (R) low (A-P view) in conjunction with
Anterior-Inferior (AI) anterior arch of atlas (lateral view)
Is an AIR atlas listing.

Adjustment on right (R) transverse process to PSL.
Spoken of as: RIGHT LOW INFERIOR SIDE SLIP.

Left (L) high (A-P view) in conjunction with
Anterior-Superior (AS) anterior arch of atlas (lateral view)
Is an ASL atlas listing.

Adjustment on left (L) transverse process to PIR.
Spoken of as: LEFT HIGH SUPERIOR SIDE SLIP.

Left (L) high (A-P view) in conjunction with
Anterior-Inferior (AI) anterior arch of atlas (lateral view)
Is an AIL atlas listing.

Adjustment on left (L) transverse process to PSL.
Spoken of as: LEFT HIGH INFERIOR SIDE SLIP.

Left (L) low (A-P view) in conjunction with
Anterior-Superior (AS) anterior arch of atlas (lateral view)
Is an ASL atlas listing.

Adjustment on left (L) transverse process to PIR.
Spoken of as: LEFT LOW SUPERIOR SIDE SLIP.

Left (L) low (A-P view) in conjunction with
Anterior-Inferior (AI) anterior arch of atlas (lateral view)
Is an AIL atlas listing.

Adjustment on left (L) transverse process to PSR.
Spoken of as: LEFT LOW INFERIOR SIDE SLIP.

At this writing, it is impossible to set up extensive figures on

frequency of different four atlas wedge-side-slips. We have an analysis of 816 cases, divided as follows:

L. HI	142
L. LO	214
R. HI	169
R. LO	291

Of this number, they were listed for adjustment as follows:

ASR	185
AIR	211
ASL	209
AIL	130
PRI-T	14
PRI-F	11
PLI-T	21
PLI-F	2
Level Occiput	
ASR	1
Level Occiput	
ASL	1
PI-F (PLI)	1

Further statistics may change and vary these figures.

Direction TO which atlas side-slips laterally (A-P view) determines laterality, as R or L.

Adjust atlas from side of POINT of wedge TO blunt side of wedge, thus equalizing both sides.

It may help in understanding of this subject if, instead of using term and thinking of "occiput" in all above descriptions, you use term and think of "condyles" by preference.

Superior or inferior of anterior arch of atlas (lateral view) determines either two directions as AI or AS.

The fact that there is an A-P view HIGH on one side or the other, with a lateral view INFERIOR, does not change the listing from being inferior (I).

The fact that there is an A-P view LOW on one side or the other, with a lateral view SUPERIOR, does not change the listing from being superior (S).

Listing wedge-side-slips, following designations are used:

R. HI (right high)

R. LO (right low)

L. HI (left high)

L. LO (left low)

Why list them at all when it does not change listing such as "ASL" for adjustment? In past that percentage of "low" has been listed according to axis rule. To adjust them that way was to wedge atlas wedge-side-slips more than before and make case worse. For that reason knowledge of "lows" prevents that occurring.

Study articulations between occiput and atlas and you find that occiput can and does rock forward and backward upon articulations of atlas, therefore could be subluxated in extremes, either forward or backward, as spinographs reveal. You will find it difficult to assume that left portion of atlas could be anterior with right portion of atlas posterior; or atlas right portion could be anterior with left portion of atlas posterior. A study of articulations between occiput and atlas shows condyles to be U-shaped in convexity on occiput, and atlas superior articulations to be U-shaped in concavity. To have it possible for atlas to become posterior on one lateral side and anterior on other lateral side, would necessitate that occipital condyles slip up and out of their normal U-shaped convexities as they fit into normal atlas U-shaped concavities; or, to create same condition, atlas U-shaped concavities would need to slip down and out of normal U-shaped convexities with occiput, in not only one side but both. This is another of those more or less natural locks which tend to prevent possibility of subluxations between occiput and atlas, producing a rotation only as entire head may rotate, with atlas, upon and around axis. Head can be and is often racked-rocked forward or backward, in excess, which, plus rotation of occiput AND atlas upon axis, gives the distorted triangular direction of torqued subluxation OF ATLAS in relation to axis, or axis in relation to atlas.

These wedge-side-slip subluxations of atlas, between occiput and axis, produces a closure and diminishment of size and shape of lumen between inferior of magnum foramen and superior of atlas. These wedge-side-slip subluxations of atlas are possible be-

cause there is NO lateral articulatory lock on either occiput or atlas, or between occiput and atlas and axis.

(We present pen and ink sketch to illustrate what happens when atlas wedge-side-slips on its articulation with occiput. You are looking from inferior of atlas up to and thru neural canal of atlas, up to and thru magnum foramen. It can be readily seen how it does occlude the natural channel thru which spinal cord passes. See Illustration No. 64.)

(See pen and ink sketch drawings, Nos. 141-142, to illustrate the anterior slip atlas subluxation.)

The adjustment to be given a wedge-side-slip torqued subluxation of atlas would be from side which IS SQUEEZING HIGH on an occiput that appears low. To adjust from greater distance separation side, would be to drive wedge more to wrong side, increase approximation of atlas to head on narrow side, and increase distance on wide side. This would decrease lumen between magnum foramen and atlas, more. The narrow side, be it left or right, high or low, would be adjusted to right or left, low or high, on condyles which have appeared to wedge-side-slip to opposite side, torqueing it according to superior or inferior as lateral view of spinographs reveals its necessity. To adjust atlas from wide side, where it is off condyles, would increase the "off" articulation condition needing correction.

A FALSE CONCLUSION WRONGLY PLACED

Destiny creates time and place for bringing forth concealed truth, revealing it thru several minds at or about same time. Like buds on same tree, at same time, they burst forth more or less simultaneously for human consumption. Where credit may be placed is immaterial; that truth has been developed for human use is the crucial issue. That interpretation be correct is vital, for upon that depends its application in practical practice. We began to limit spinal practice to limited areas in 1923 when the NCM developed a new line of facts on interferences. In spring of 1930 we definitely reduced area to occiput, atlas, and axis. Your author has issued observations monthly from 1930 on, of recent years, issuing an annual book on his research; teaching these developed successive steps in many places to many people. It would be natural that others should begin thinking similar lines, of similar conditions, at similar locations. Outside of this author's writings, there have been no other contemporary writ-

ings bearing upon similar subjects, except two short squibs hardly worthy of being called articles, explanatory of the greatness of this issue. Both articles were in part requotes of principles and practices we laid down in our *Hole in One* work (one of them several times even referring to such in direct terms), except modified sufficiently in characteristics to completely change the fundamental and destroy, in a percentage of cases, its value. Our premise, as this book reveals, has been and is that ATLAS is subluxated, as a wedge, BETWEEN occiput above and axis below; and ATLAS must be vertebra adjusted. Both contemporary writers assume it is CONDYLES that are subluxated ON atlas and CONDYLES must be adjusted. That there is a changed relation between condyle AND atlas is obvious, which we clearly set forth in this work. To attempt to adjust condyles above as a remote place of adjustment, is as bad as to attempt to adjust axis, 6th Cervical, 6th Dorsal, or 3rd Lumber below, as a remote place of adjustment. (In Chapter V we have discussed at length this question of remote adjustment). ATLAS being THE subluxated vertebra, the more removed therefrom the attempted adjustment, the more remote the correction, the more remote the results and the greater the liability to PRODUCE subluxation and the less likely to REDUCE it. Our writings began to appear on this subject in spring of 1930. Our contemporaries' squibs appeared in a trade journal in Jan. '33 and Dec. '33.

Discussing this subject, the one squib of passing notice makes following comments and erroneous conclusions:

"In listing the condyles from a spinographic film—we consider a horizontal plane of the occiput and the mastoid processes—if the RIGHT mastoid process and the RIGHT side of the occipital bone are found to be SUPERIOR to the left mastoid and occipital bone, it would be listed AS A RIGHT condyle or vice versa."

The article nowhere tells what to expect—if RIGHT mastoid and RIGHT side of occipital bone are found INFERIOR to left mastoid and occipital bone, or what THAT would be listed as, or vice versa.

"Bear in mind — when THE CONDYLE IS SUBLUXATED TO THE RIGHT, there one other direction it may

move AND THAT IS SUPERIOR, and the same way when it is subluxated to the left, it can only move superior and it is for this reason that the above-mentioned land marks WILL ALWAYS BE FOUND SUPERIOR in the direction IN WHICH THE CONDYLE IS SUBLUXATED."

The above comments on this important articulation, from which this same article says he "believes that practically all cord pressure, perhaps 95% of it, originates between the occiput and the atlas," are the essence of his comments bearing importance. Even these are only part true and all conclusions therein reached are untrue in fact.

1. ONE vertebra by itself could not be subluxated.
2. TWO vertebrae, by themselves, could not be subluxated within themselves because it leaves either one as THE one that COULD BE subluxated in relation with other.
3. It requires ONE ELEMENT BETWEEN TWO ELEMENTS out of alignment to create a subluxation. Occiput, having no comparison superior to itself, therefore condyles of occiput of skull cannot be subluxated on atlas.
4. ATLAS inferior to condyles and superior to axis CAN BE subluxated BETWEEN occiput AND axis.
5. No vertebra IS subluxated unless it contains THREE-DIRECTIONED locked or torqued permanent wrench. One vertebra in relation to one vertebra cannot possess THREE-DIRECTIONED locked or torqued permanent wrench. It must be inter-mediary BETWEEN vertebra above and below to make possible THREE NECESSARY elements of subluxation.

With occiput, atlas, and axis in hand, follow description as quoted in this contemporary squib article:

"—if the RIGHT mastoid process and the RIGHT side of the occipital bone are found TO BE SUPERIOR to the left mastoid and occipital bone, it would be listed AS A RIGHT CONDYLE or vice-versa."

To have a "RIGHT mastoid process and RIGHT side of occipital bone SUPERIOR," would necessitate a LEFT LOW WEDGE SIDE SLIP SUBLUXATION OF ATLAS. Atlas is wedged TO LEFT, throwing LEFT condyle low and RIGHT condyle high. To adjust right condyle as a RIGHT subluxation, from right TO

left, would drive wedge tighter TO LEFT and increase interference between atlas and occiput in inter-magnum-atlas-foramen neural canal space.

"When condyle is subluxated TO RIGHT, there is only one other direction IT may move and that is SUPERIOR." Let us correct that statement. When right condyle appears TO right and is SUPERIOR on right, ATLAS has wedge-side-slipped TO LEFT which brings atlas high on left and low on right; or measured by position of occiput, is low on left and high on right. CONDYLE IS NOT SUBLUXATED. ATLAS IS. To attempt to "adjust" SUPERIOR condyle right or left, is to jam wedge-side-slip of atlas to opposite direction more.

6. It is NOT occiput that is subluxated—it is atlas.
7. It isn't occiput that is subluxated RIGHT—it is atlas LEFT.
8. It isn't occiput subluxated SUPERIOR — it is atlas INFERIOR OR LOW.
9. All they suggest is occiput SUPERIOR. It can also be LOW on either side and frequently is, as spinographs reveal.

Their analysis of that problem shows hasty judgment, immature study of a vital subject.

AXIS SUBLUXATIONS

Look at an A-P spinograph, where a major portion of posterior inferior of skull is showing, and you observe that if head is inferior on right; atlas is inferior on right, and body of axis is inferior on right, spinous process of axis will be to left (on an A-P view) of median line.

When head, atlas, and axis are inferior on right, skull will lean over and backward towards right shoulder (judging from both A-P and lateral views). When that condition exists, head will not only lean towards and over onto right shoulder, but it will also lean posterior (lateral view) and inferior (A-P view) or posterior inferior. From lateral view, axis spinous process will be inferior. A lateral view will show anterior of body of axis is superior in a separation between it and 3rd cervical. This separation between axis and 3rd cervical is a misalignment. Torque subluxation could be between atlas and axis. Subluxation might be a torque between atlas and axis. This would be

a TRUE PLI subluxation and torqued adjustment to ARS would be necessary to straighten this entire kink.

Look at another A-P spinograph, where a major portion of posterior inferior of skull is showing, and you observe that if head is inferior on left; atlas is inferior on left, and body of axis is inferior on left. Spinous process of axis will be to right, (on an A-P view) of median line. When head, atlas, and axis are inferior on left, skull will lean over and backward towards left shoulder (judging from both A-P and lateral views). When that condition exists, head will not only lean towards and over onto left shoulder, but it will also lean posterior (lateral view) and left (A-P view) or posterior and left. From lateral view, axis spinous process will be inferior. A lateral view will show anterior of body of axis is superior in a separation between it and 3rd cervical. This separation between axis and 3rd cervical would be a misalignment. Torque subluxation could be between atlas and axis. Subluxation might be a torque between atlas and axis. This would be a TRUE PRI subluxation and torque adjustment to the ALS would be necessary to straighten this entire kink.

(If this subject be entirely new; or if you have had a limited introduction to it; or even if the subject be old, we again suggest that you have two view boxes, with A-P view in one, Lateral in other; and then check these points on films as you read this book, item by item. Here is a fine work for your NCM Research Club to do. One read. then check films to verify.)

If head, atlas, and axis are low on right; spinous process of axis is left of median line, and head leans down over onto right shoulder, and there exists a misalignment between axis and third cervical. Torqued adjustment, given from PLI toward ARS would raise axis, atlas and head on right side; straighten head from leaning towards right to a position in median line; also, by raising spinous process of axis from inferior to superior, it would correct misalignment between axis and 3rd cervical. With one TORQUED adjustment, all local as well as foreign elements of torqued subluxation are corrected.

If head, atlas, and axis are low on left; spinous process of axis is right of median line, and head leans down over onto left shoulder; and there exists a misalignment between axis and 3rd cervical. Torqued adjustment, given from a PRI towards ALS would raise axis, atlas, and head on left side; straighten head

from leaning towards left to a normal position in median line; also, by raising spinous process of axis from inferior to superior, it would correct misalignment between axis and 3rd cervical. With one TORQUED adjustment, all local as well as foreign elements of torqued subluxation are corrected.

There are four possible seeming exceptions to this common torqued subluxation rule that might misdirect your attention and cause you to violate these simple possible conditions:

1. In first instance, where everything is low on right, spinous process is to left of median line; yet, on a lateral view, spinous process of axis appears SUPERIOR. In this condition you might assume that it was a TRUE PLS subluxation. Even though spinous process IS superior, adjust it as for a PLI.

(Be careful to not confuse the "superior axis spinous process" as here referred to, with a similar given rule regarding how to ascertain "Is It Atlas" under that heading in Chapter XI.)

2. In second instance, where everything is low on left, spinous process is to right of median line; yet, on a lateral view, spinous process of axis appears SUPERIOR. In this condition you might assume that it was a TRUE PRS subluxation. Even though spinous process IS superior, adjust it as for a PRI.

The torque adjustment in No. 1 would be from PLI to ARS and NOT from PLS to ARI.

The torque adjustment in No. 2 would be from PRI to ALS and NOT from PRS to ALI.

3. If in first instance, where everything is low on right, but spinous process of axis appears to RIGHT of median line, you determined position of a TORQUED subluxation by position of spinous process alone, you would conclude this was a PRI subluxation and torque your adjustment to ALS. You must not judge position of a TORQUED SUBLUXATED VERTEBRA from position of spinous process, but from position of entire balance of vertebra minus its spinous process. Spinous processes are often bent in youth in cartilaginous stage; or possess a green-stick fracture attained in later years. Even though head, atlas, and axis are low on right AND spinous process of axis is to RIGHT of median line, adjustment would be as though it were a PLI and is to be adjusted to ARS.

4. If in second instance, where everything is low on left, but

spinous process of axis appears to LEFT of median line, you determined position of a TORQUED subluxation by position of spinous process alone, you would conclude this was a PLI subluxation and torque your adjustment to ARS. You must not judge position of a TORQUED SUBLUXATED VERTEBRA from position of spinous process but from position of entire balance of vertebra minus its spinous process. The position of spinous process does not indicate a spinous process subluxation alone. Spinous processes are often bent in youth in cartilaginous stage; or possess a green-stick fracture attained in later years. Even though head, atlas and axis are low on left and spinous process of axis is to LEFT of median line, adjustment would be as though it were PRI and is to be adjusted to ALS.

The same rule applies to where head, atlas, and axis may be low on right, spinous process to RIGHT AND SUPERIOR. This would be a PLI TORQUED subluxation and should be adjusted to ARS. The opposite would also be true where head, atlas, and axis may be low on left, spinous process to LEFT AND SUPERIOR. This would be a PRI TORQUED subluxation and should be adjusted to ALS.

We elaborate more on this question later.

Later on in this article you are going to become impressed with the fact that, regardless of where anterior or posterior tubercles of atlas are; regardless of where spinous process of axis is, these within themselves, per se, do not produce pressures or interfere with transmissions of mental impulse supply. You will also learn that regardless of where tubercles or spinous processes comparatively are in relation to skull or between themselves, the vital issue is not to comparatively locate tubercles or spinous processes, but what damage does the abnormal position OF THE ENTIRETY of the position of the atlas upon the axis; the abnormal position OF THE ENTIRETY of the axis in relation to the atlas; and how the abnormal position OF THE ENTIRETY of either affects the INTER-MAGNUM-ATLAS FORAMEN and THE ODONTOID PROCESS which DO occlude the spinal canal, DOES produce pressure upon nerves, and DOES interfere with transmission.

Illustration No. 126.

Normal view, inferior portion of occiput and cervical region, showing location of transverse process of atlas and spinous process of axis.

Illustration No. 127.

Showing skull of cervical region with head lying in position on adjusting table, for adjustment. Nail point one must be placed directly on transverse process of atlas or inferior to spinous process of axis. The average Chiropractor places nail point one on lamina of atlas posterior to transverse process of atlas, or lamina of axis anterior to spinous process.

Illustration No. 128.

This illustrates how to correctly place the nail point one of nail hand on transverse process of atlas. Study of this picture will reveal that nail point one is not on the lamina of atlas.

Illustration No. 129.

This illustration portrays how to place nail point one under spinous process of axis. Careful study shows that it is under the spinous process and is not on the lamina anterior to it.

Illustration No. 130.

Patient lying on table. Nail point one of nail hand is arched so that nail point one is directly on transverse process of atlas. Note particularly that nail hand is up on cutting edge. Note that thumb and ball of hand are not down touching neck at or about region of 7th cervical.

Illustration No. 131.

Nail point one of nail hand is under spinous process of axis. Note how nail hand is placed around, on, and under spinous process of axis. The average Chiropractor carelessly places nail point one or two on lamina of axis which would be anterior to position as portrayed in this picture.

Illustrations 132 to 136 inclusive show office practice and position to assume balance in adjusting.

Illustration No. 132.

In the text of this book, we have earnestly suggested the tailor-made adjustment for each particular patient to correspond with the equivalent valuation of each of the three differing direc-

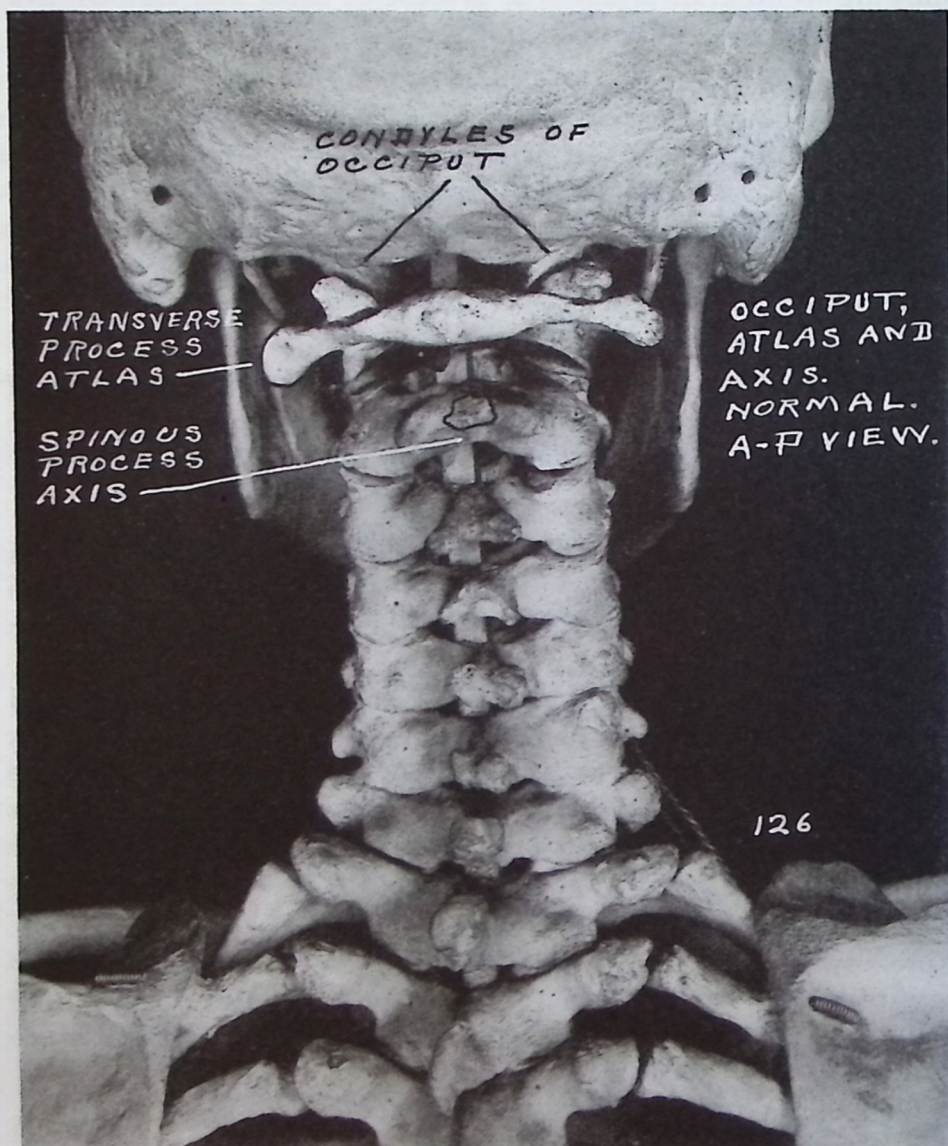


Illustration No. 126

tions of subluxation in that particular case. Illustration 83 shows an office set-up. Two view-boxes, showing A-P and lateral view of the spinographs of the patient lying on the adjusting table. The Chiropractor, while studying the spinographs, practices the particular torque necessary for the varying directions of that subluxation as shown in the view-boxes. Having untorqued it on the rubber-top practice stool, to his satisfaction, he then steps to the patient and makes the adjustment as observed in Illustration No. 133.

Illustration No. 133.

While making the adjustment upon the patient, he still observes the spinographs and with the picture in mind, he then directs his hands to correspond with the valuations of the picture as portrayed; then tailor-making the adjustment for the patient as revealed by the spinographs of that patient.

Illustration No. 134.

No. 133 and 134 illustrate the position of body to the right and left of the patient, in order to establish a perfect balance in the delivery of that adjustment. No. 133 and 134 as viewed from the rear to get the lateral position of that body in that balance.

Illustration No. 135.

A lateral view of position of body of adjuster, showing balance in order to better untorque the torqued subluxation. This illustration taken from the left side of patient on a PLI axis.

Illustration No. 136.

Lateral view of position of body of Chiropractor, giving adjustment upon PRI axis subluxation. Note emphasis of arched hand in Illustrations 133, 135, and 136, wherein thumb and ball of hand do not touch neck at any place except the arched nail point No. 1. Chiropractors frequently and carelessly let the entire ball of the hand rest on the neck, so that the pisaform is on the lamina and ball of hand at base of thumb usually lies down on 6th or 7th cervical and when thrust is given, separates head from base of cervical region. Great care must be exercised to keep nail hand always arched, focalizing the forces at one point:

Illustration No. 137.

THE B.J. SPECIAL ADJUSTING TABLE. Side view. Built according to correct height, slant of front table top, padding to permit cervical adjusting; all adjustable lengths, knee pad at proper distance, plenty of foot room for balance stance. Made to make adjustments exactly right.

Illustration No. 138.

THE B.J. SPECIAL ADJUSTING TABLE. End view. Front bench narrow to permit shoulder-body to fit correctly for perfect placing of shoulders and head, with cervical neck "floating" for HIO specific recoil adjusting. Small but compact with no extras.

Illustration No. 139.

THE B.J. SPECIAL ADJUSTING TABLE. With patient properly placed for adjusting specific subluxations.



Illustration No. 127

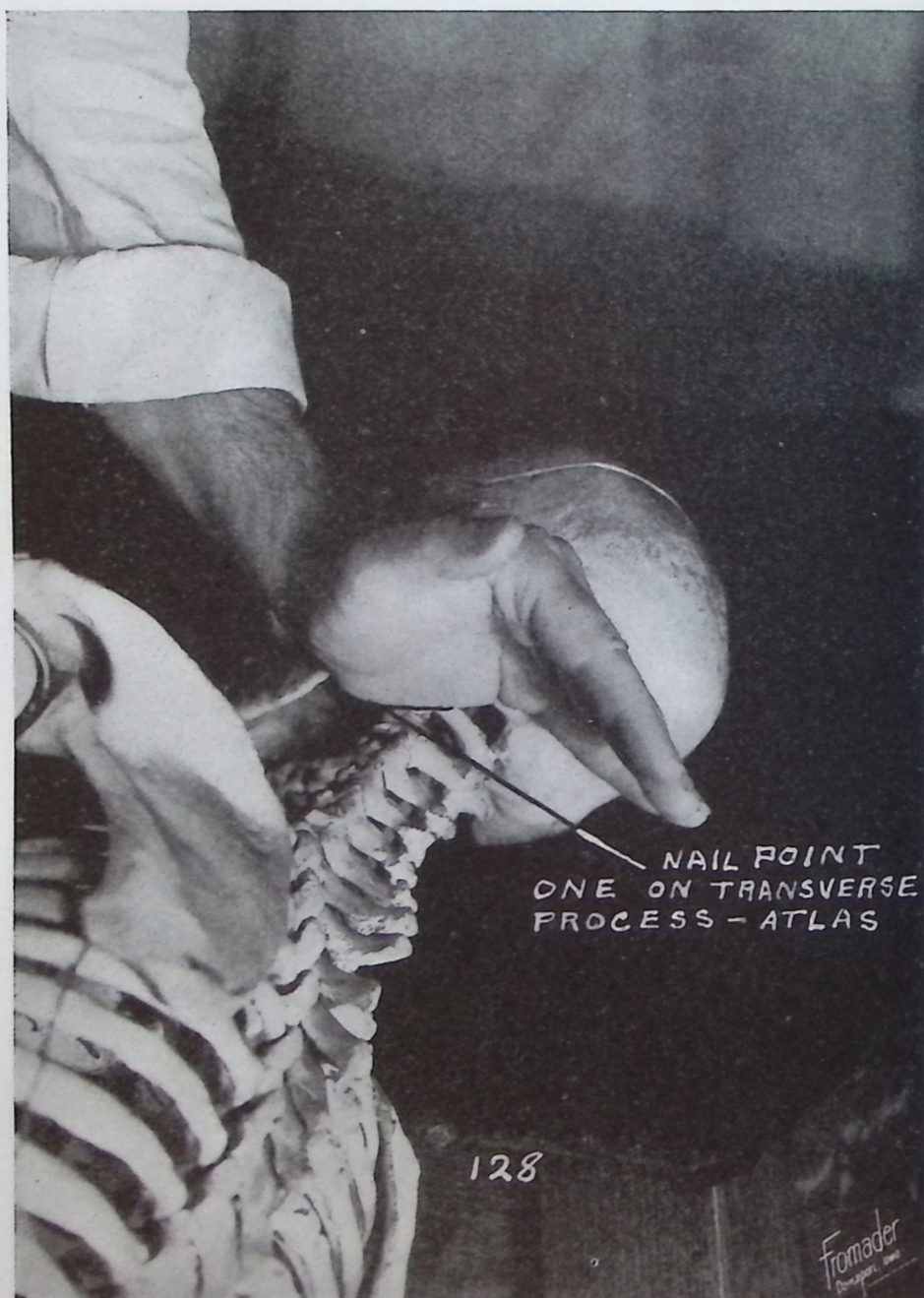


Illustration No. 128

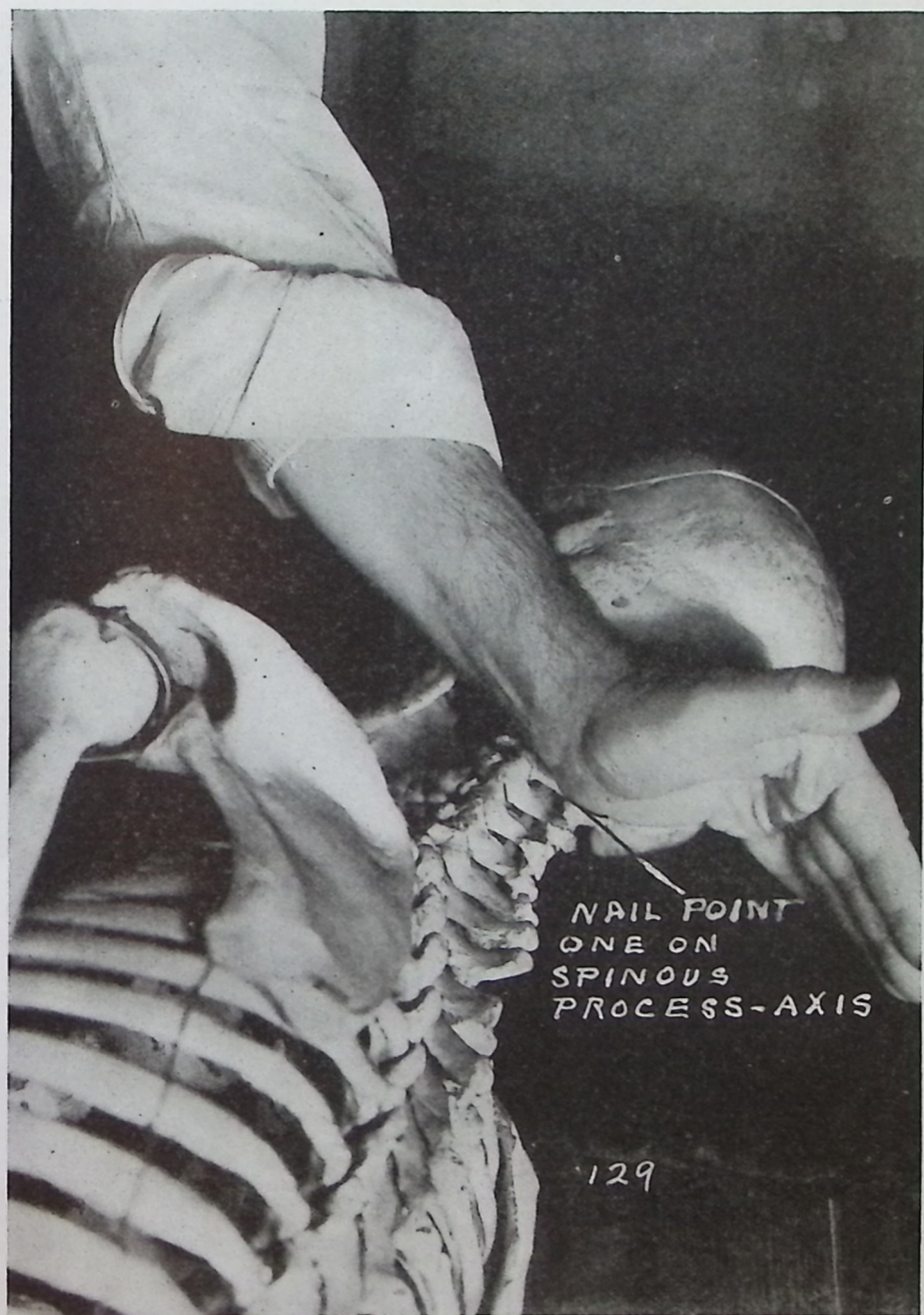


Illustration No. 129

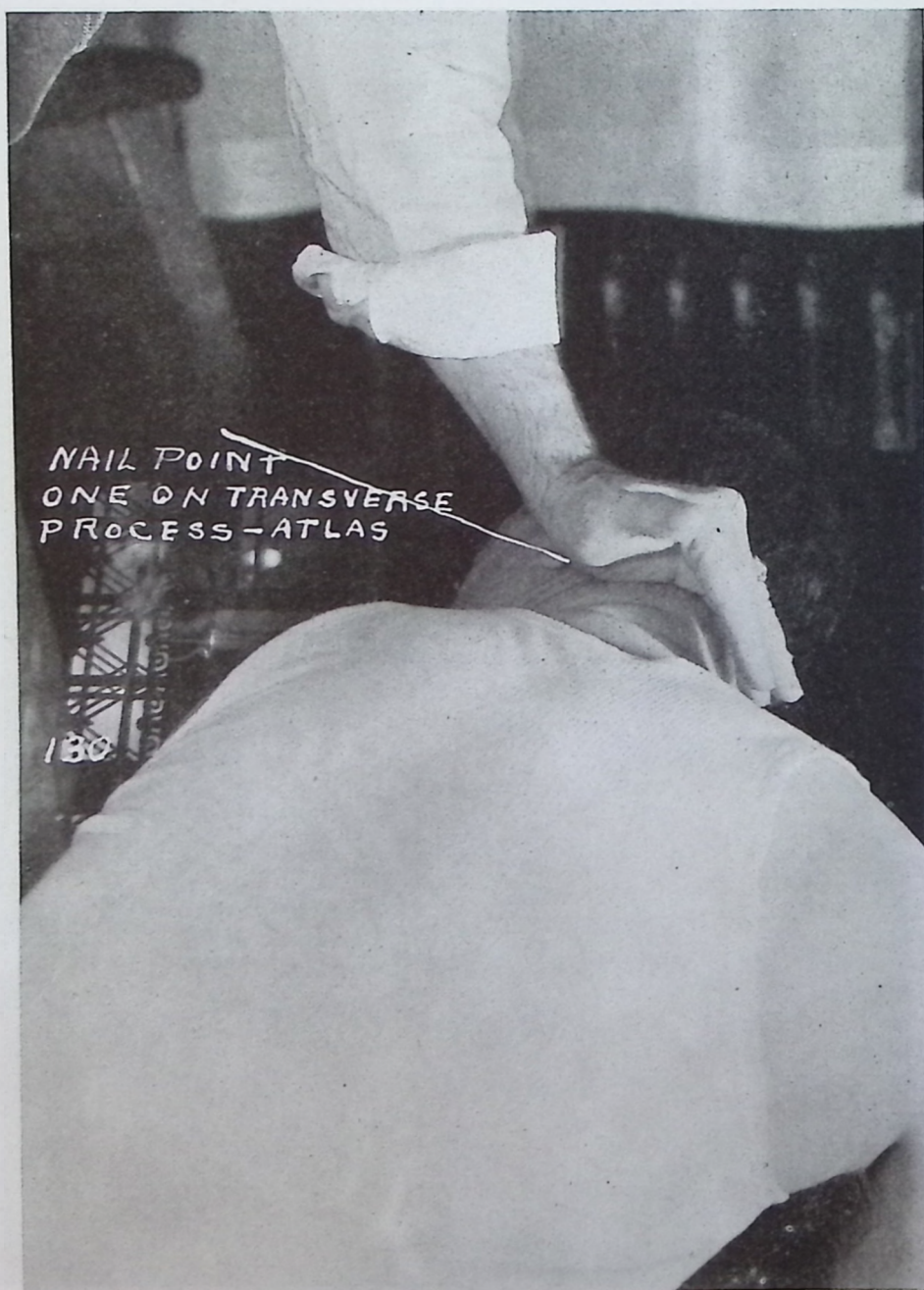


Illustration No. 130

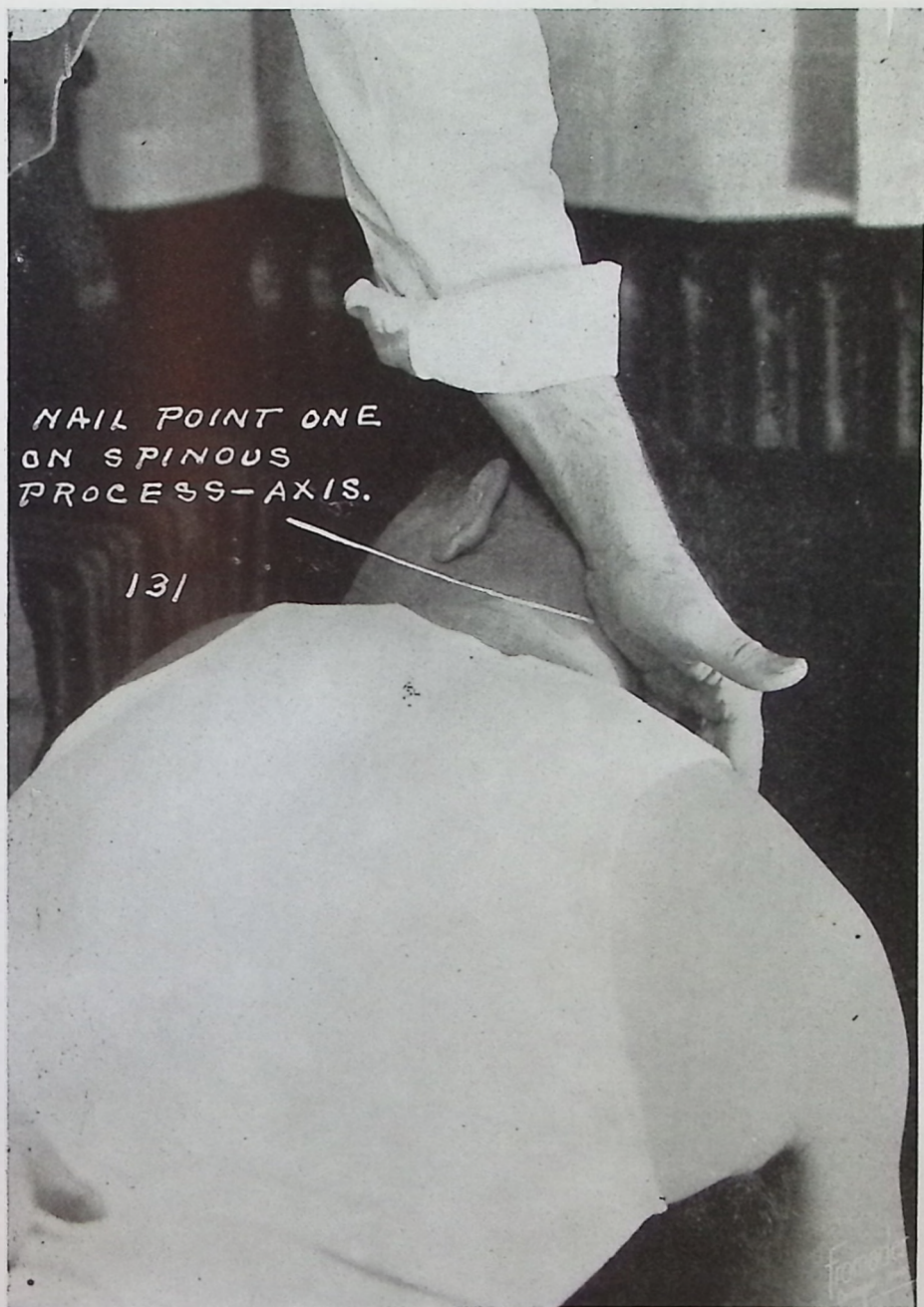


Illustration No. 131



Illustration No. 132



Illustration No. 133



Illustration No. 134

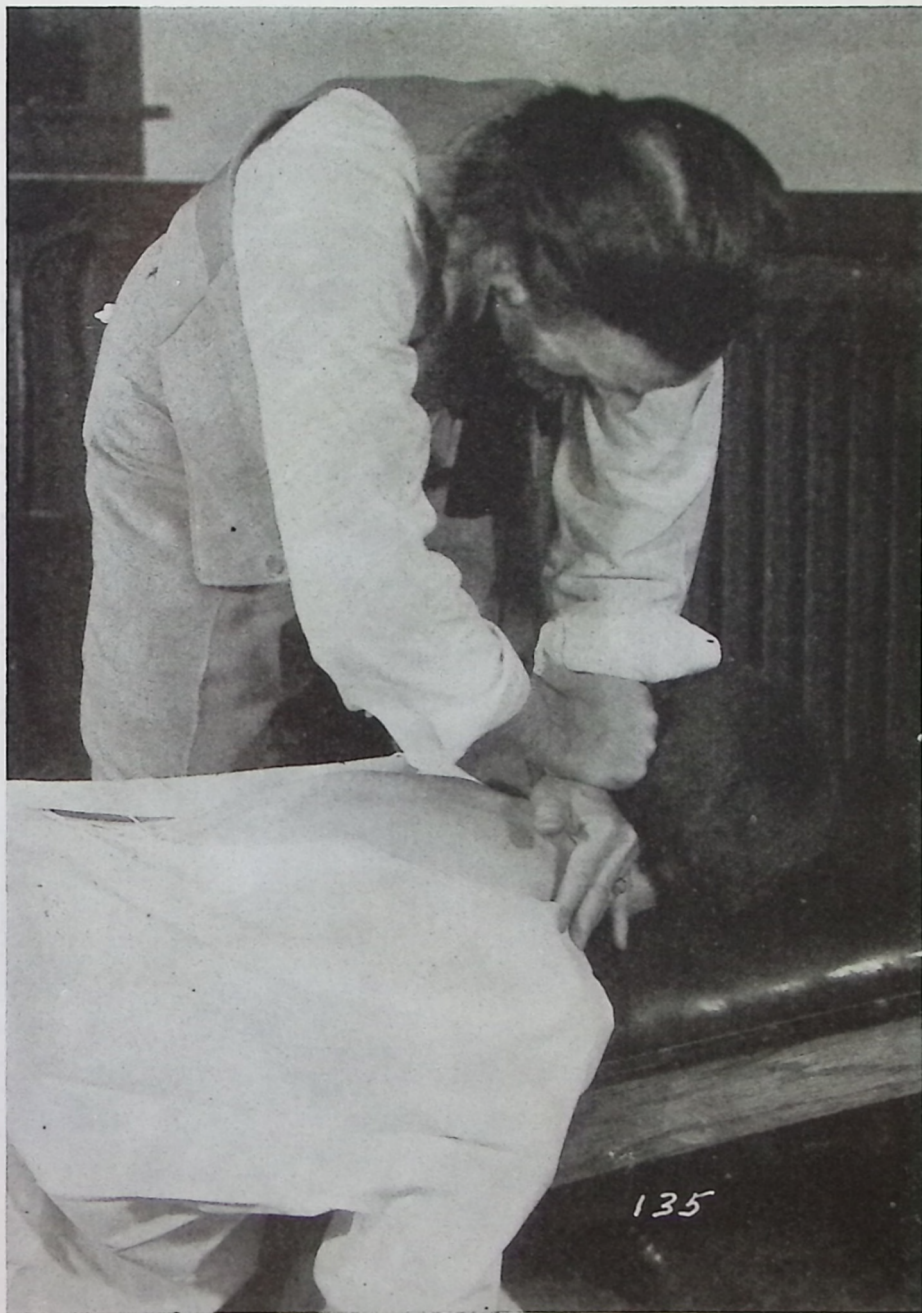


Illustration No. 135

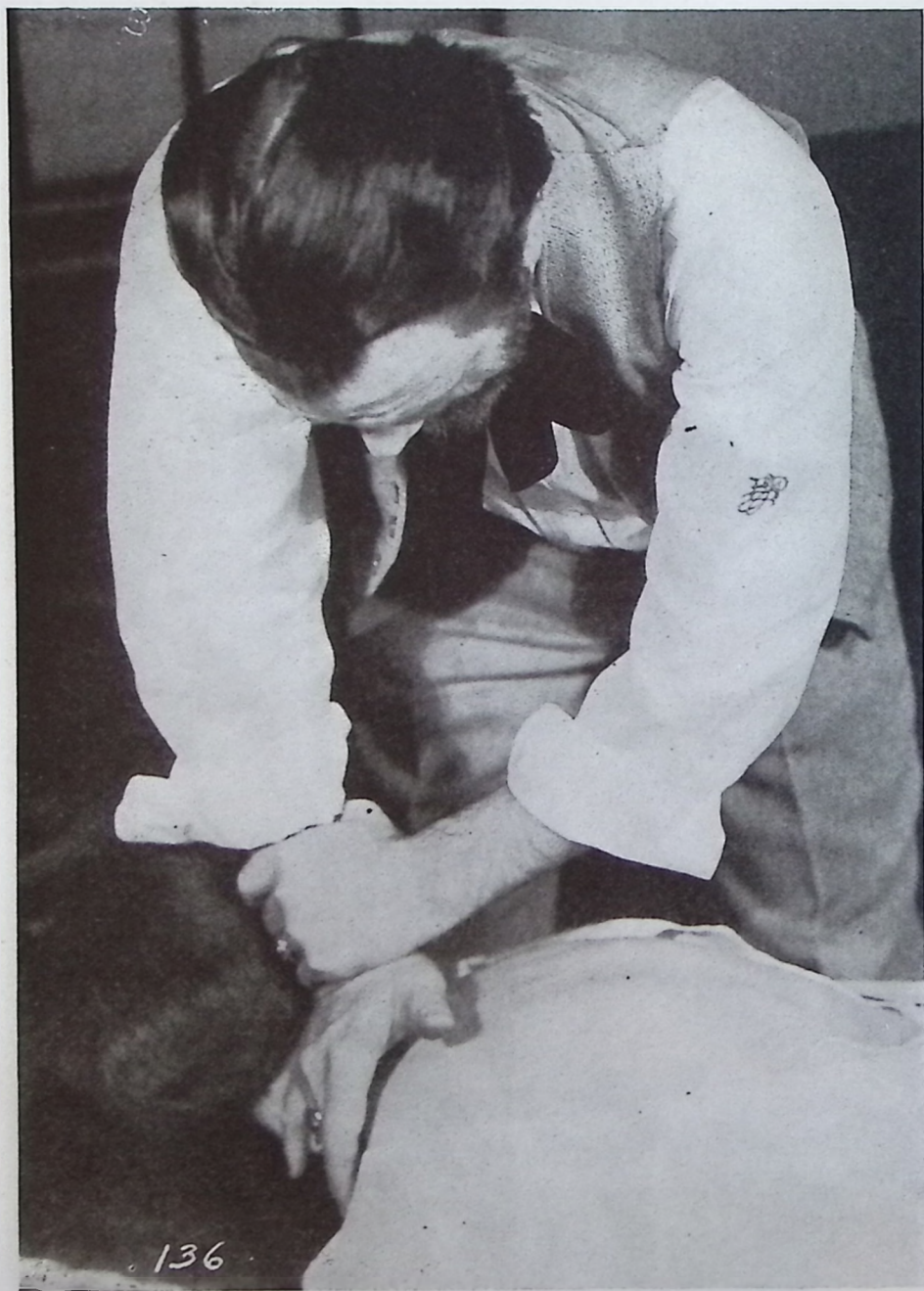


Illustration No. 136

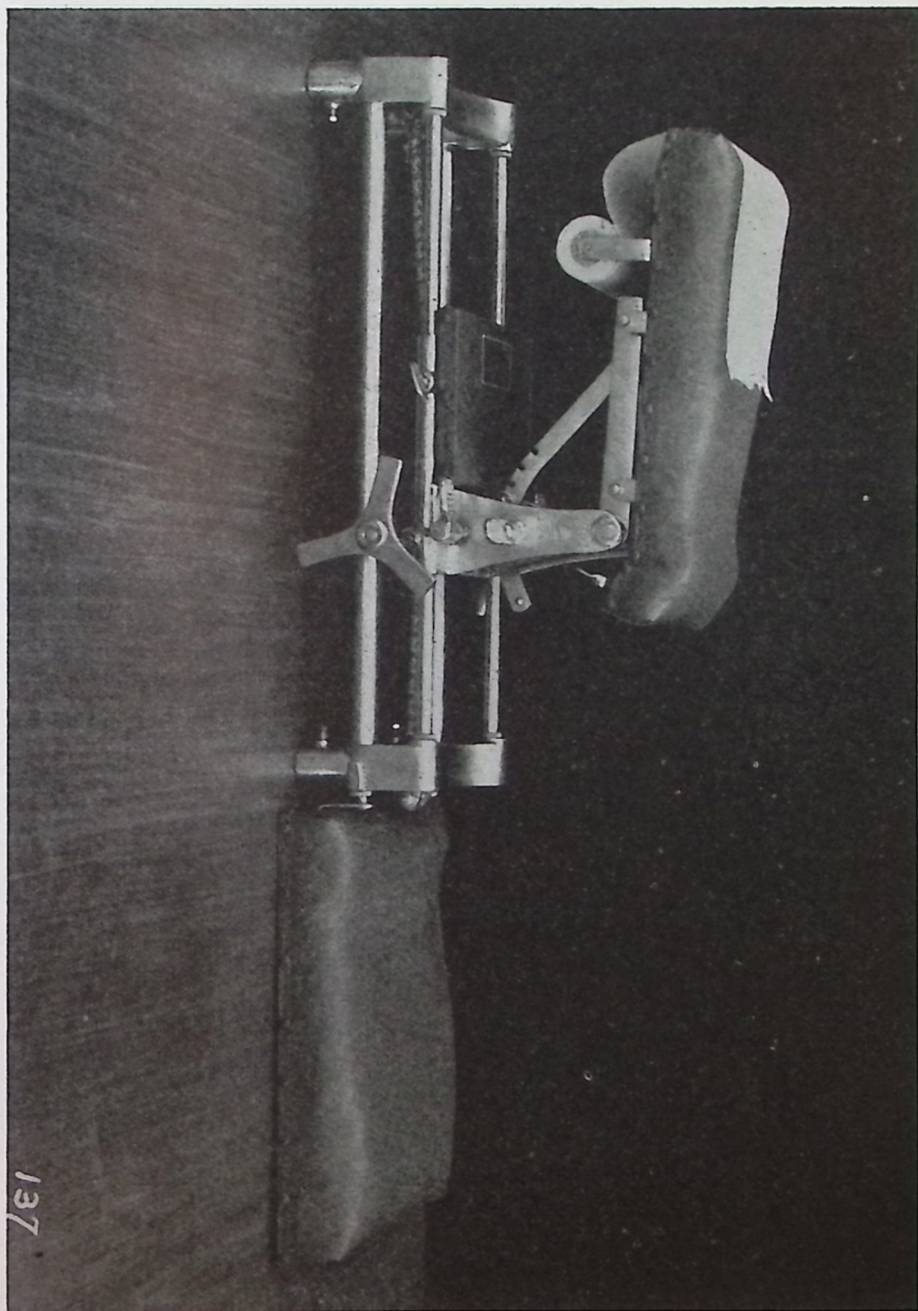


Illustration No. 137

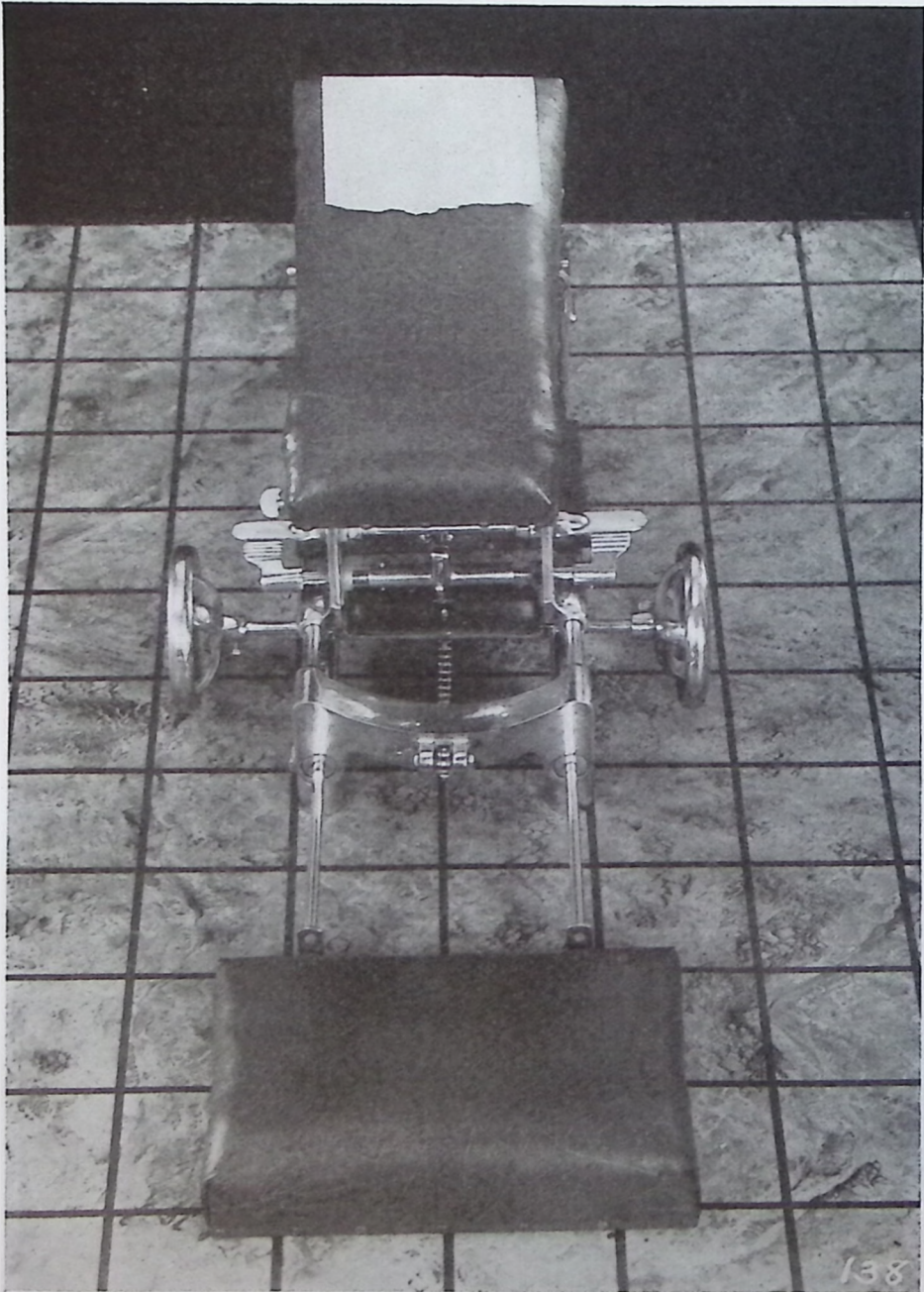


Illustration No. 138

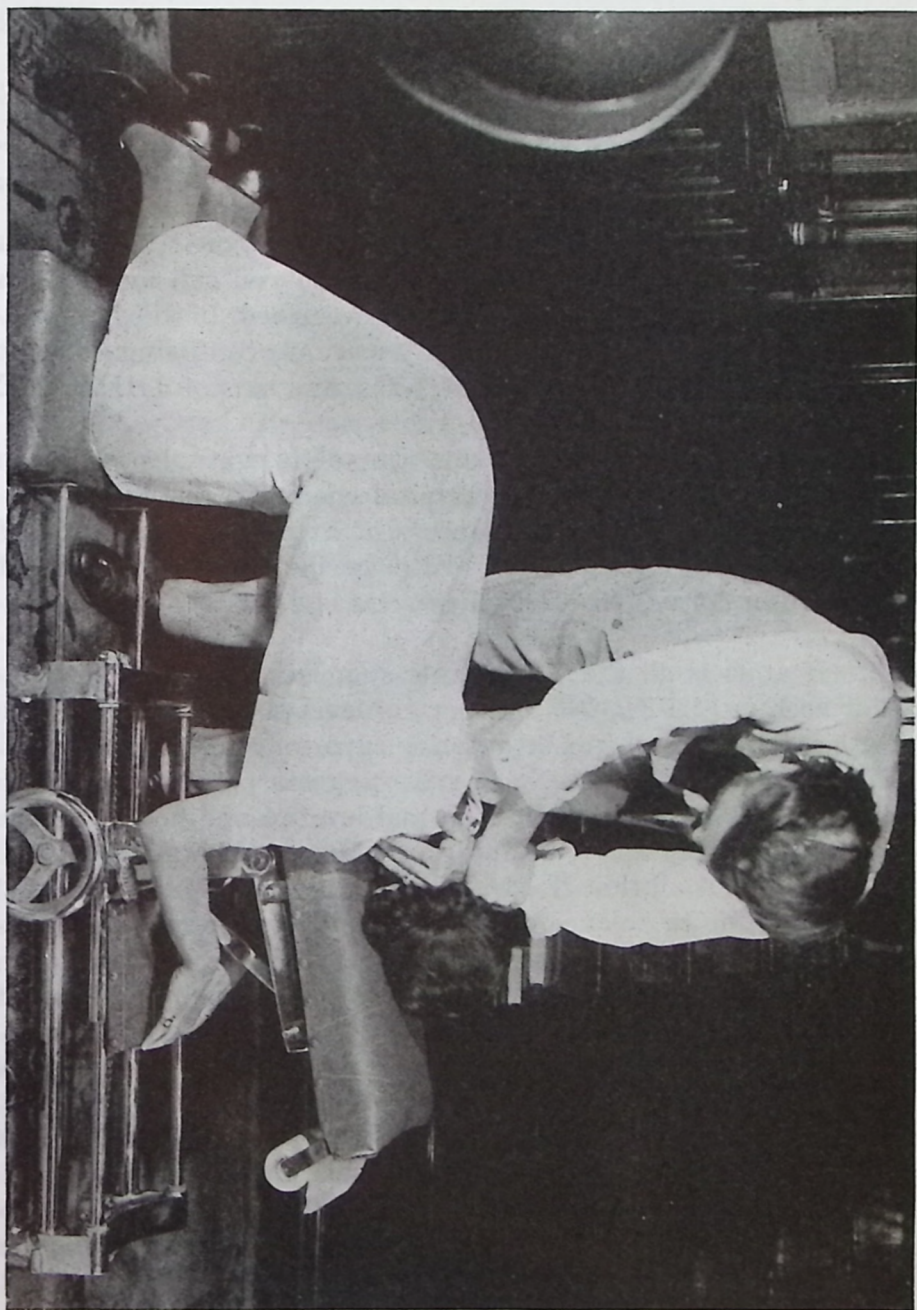


Illustration No. 139

CHAPTER XI.

IS IT ATLAS?

(To correctly analyze an atlas subluxation is more difficult than to correctly analyze an axis. We suggest you get what you think is "an atlas" and check it against any and all of rules here laid down. If it allies, it is; if it repels, it is not.)

In presenting atlas wedge-side-slip subluxations, if you can have an occiput, atlas, and axis together so you can move them about and fit them to language herein described, it will help materially to grasp the subluxations. Words are confusing without visual pictures. To get an occiput, atlas, and axis of THE SAME person is difficult.

1. If atlas anterior arch is anterior of its normal position in relation to articulations with occipital condyles; and simultaneously is anterior of odontoid process of axis; in other words, if atlas is wedged anterior BETWEEN occiput and axis, both of which are in normal position; then atlas is an A or anterior subluxation.

2. If atlas is all that No. 1 rule suggests plus fact that anterior arch is SUPERIOR to a normal level-plane-line of balance of atlas, then it is an AS or anterior superior subluxation.

3. If atlas is all that No. 1 rule suggests plus fact that anterior arch is INFERIOR to a normal level-plane-line of balance of atlas, then it is an AI or anterior inferior subluxation.

4. If atlas is all that No. 1 appears to be, superior to a normal level plane line to balance of atlas, it still may be anterior atlas in preference to a posterior inferior axis. Other conditions, such as (a) position of axis in relation to 3rd cervical; (b) position of head, whether forward or backward; (c) adaptative or compensatory curve of balance of cervical region, may still determine that it is an atlas either AS or AI.

5. In all AIR or AIL atlas subluxations, abnormal positions of head as well as cervical portion of spinal column vary considerably. In positions of head, they may be posterior, MUCH posterior, or VERY much posterior. In cervical anterior curves or lateral curves, they may be almost straight, SLIGHTLY curved, MUCH curved, or VERY much curved. All can be adaptative compensations to torqued atlas subluxations and are of value to

know only where a close decision on which an atlas is involved, is hard to make.

6. Anterior and superior (AS) torqued subluxations of atlas exhibit two positions of Axis:

- (a) Where it is seemingly normal so far as crowding or jamming of spinous processes are concerned, and where there does not appear to be any great separation of the anterior-inferior of axis centrum from superior 3rd cervical centrum. In this event, if atlas is superior (S) the odontoid of axis leans either posterior in the neural canal or slightly posterior and obliquely superior and posterior.
- (b) Where axis is inferior so far as crowding or jamming of spinous processes are concerned and where there does appear to be a separation of the anterior-inferior of axis centrum from superior 3rd cervical centrum. In this event, if atlas is Superior (S) and the base of odontoid of axis is pulled posterior in neural canal or slightly anterior and obliquely superior and anterior.

(See Illustration No. 87.)

7. If anterior arch of atlas is anterior and inferior, the posterior arch is usually superior, but occasionally may be level. If anterior arch of the atlas is anterior and superior, the posterior arch is usually inferior, but occasionally may be level. Most always, when atlas is subluxated anterior, superior or inferior, the opposite arch (posterior) is in opposite direction, viz., if inferior is superior; if superior is inferior.

(See Illustration No. 82.)

8. If you are of the opinion, after studying both A-P and lateral views, that atlas IS ASL; check back again on A-P and see if axis appears PLI. If head is low on right, atlas and axis are low on right, and spinous process of axis is left of median line, then your assumption that atlas IS ASL may be correct.

(See Illustrations No. 90-91.)

9. If you are of the opinion after studying both A-P and lateral views, that atlas IS ASR, check back again on the A-P and see if axis appears PRI. If head is low on left, atlas and axis are low on left, and spinous process of axis is right of median line, then your assumption that atlas IS ASR may be correct.

(See Illustrations No. 88-89.)

10. If you are of the opinion, after studying both A-P and lateral views, that atlas IS ASR, check back again on A-P and see if axis appears FALSE PRI. If head is low on left, atlas and axis are low on left, and spinous process of axis is left of median line, and it becomes a false PRI, then your assumption that atlas IS ASR may be correct.

(See Illustrations No. 85-86.)

11. If you are of the opinion, after studying both A-P and lateral views, that atlas IS ASL, check back again on A-P and see if axis appears FALSE PLI. If head is low on right, atlas and axis are low on right, and spinous process of axis is right of median line, and it becomes a false PLI, then your assumption that atlas IS ASL may be correct.

(See Illustrations No. 83-84.)

12. When spinous process of axis APPEARS bent superior and the anterior of centra between axis and 3rd cervical are not separated, and the odontoid points obliquely anterior in neural canal, the atlas is torqued anterior superior, on either left or right side.

13. In an apparently true PRI axis and the atlas were apparently torqued and it is difficult to decide which, the tendency would be for atlas to be ASR, atlas rotation being anterior with rotation of body of axis being R superior according to PRI axis rule. If axis were apparently false PRI, and atlas were apparently torqued and it is difficult to decide which, the tendency would be for atlas to be AIL, atlas rotation being L posterior with rotation of body of axis anterior on R and superior according to the false PRI axis rule.

14. If the axis is misaligned seemingly PS (as would be listed according to position of spinous process) the tendency is for the odontoid to push atlas anterior and superior, causing kink between foramen magnum and posterior arch of atlas. Axis spinous process, seemingly bent PS, forms distinct misalignment between axis and 3rd C.

15. If head is high on right, atlas is side-slipped to right, and distance between any given point on atlas and a like given place on occiput, on right, is less than it is on left; and if same given points on left side are greater than on right, then it may be a right-high side-slip atlas.

16. If head is high on left, atlas is side-slipped to left, and distance between any given point on atlas and a like given place on occiput, on left, is less than it is on right; and if same given points on right side are greater than on left, then it may be a left high side-slip atlas.

17. If head is low on right, atlas is side-slipped to right and distance between any given point on atlas and a like given place on occiput, on right, is less than it is on left, and if same given points on left side are greater than on right, then it may be a right low side-slip atlas.

18. If head is low on left, atlas is side-slipped to left, and distance between any given point on atlas and a like given place on occiput, on left, is less than it is on right; and if same given points on right side are greater than on left, then it may be a left low side-slip atlas.

IS IT AXIS?

(To correctly analyze an axis subluxation is easy. Its rules are more simple. We still suggest it is well to have spinographs in your view-boxes that you may check facts herein listed as against actual films; thereby gaining not only mental but optical understanding. After all, pictures create clearer knowledge than words.)

(In all discussions, in all Chapters of this book, we take it for granted—to save constant reiteration—that presence or absence of interference to transmission of mental impulse supply has been accurately and competently ascertained with NCM in making the final conclusion. We use term “subluxation” constantly with THAT in mind.)

When head is low on right
atlas is low on right
axis is low on right
and axis spinous process is LEFT of median line,
the torqued subluxation is a TRUE PLI subluxation
of axis.

(See Illustrations No. 66, 67 and 68.)

When head is low on right
atlas is low on right
axis is low on right
and axis spinous process is RIGHT of median line.
the torqued subluxation is a FALSE PLI subluxation
of axis.

It is “FALSE” because spinous process is ON RIGHT side where it DOES NOT BELONG; and is NOT on LEFT side where

IT DOES belong. The spinous process violates the TRUE PLI rule, viz., the spinous process MUST be to LEFT of median line. The difference between these two listings is: In TRUE, the entire vertebra, INCLUDING THE SPINOUS PROCESS is a PLI subluxation. In FALSE, entire vertebra, MINUS SPINOUS PROCESS, is a PLI subluxation. In FALSE, the spinous process was bent in either its cartilaginous form in early youth, or there is a malformed laminar growth wherein LEFT lamina is atrophied and RIGHT lamina is hypertrophied; either of which allows the ENTIRE VERTEBRA to be subluxated according to a TRUE PLI rule except for spinous process which distorts itself to FALSE PLI rule.

(See Illustrations No. 72, 73 and 74.)

(See Illustrations No. 113, 114.)

The objective of the torqued adjustment, in either of the above cases, IS TO UNTORQUE THE TORQUED SUBLUXATION. This requires:

head low on right
atlas low on right
axis low on right

and axis spinous process to LEFT or RIGHT of median line must be raised superior ON RIGHT. To do this requires that the torqued subluxation, either TRUE PLI or FALSE PLI must be untorqued by adjustment FROM PLI IN BOTH INSTANCES; therefore both conditions would be listed as tho both were PLI subluxations. If spinous process is to RIGHT of median line, then this torqued subluxation must still be untorqued by adjustment FROM PLI; therefore spinous process being to RIGHT is a FALSE position of spinous process but a true position of the vertebral subluxation.

When head is low on left
atlas is low on left
axis is low on left

and axis spinous process is RIGHT of median line, the torqued subluxation is a TRUE PRI subluxation of axis.

(See Illustrations No. 69, 70 and 71.)

When head is low on left
atlas is low on left
axis is low on left

and axis spinous process is LEFT of median line, the torqued subluxation is a FALSE PRI subluxation of axis. It is "FALSE" because spinous process is ON LEFT side where it DOES NOT BELONG; and is NOT on RIGHT side where IT DOES belong. The spinous process violates TRUE PRI rule, viz., spinous process MUST be to RIGHT of median line. The difference between these two listings is this: in the TRUE entire vertebra INCLUDING SPINOUS PROCESS is a PRI subluxation. In the FALSE, entire vertebra MINUS SPINOUS PROCESS is a PRI subluxation. In the FALSE, spinous process was bent in either its cartilaginous form in early youth, or there is a malformed laminar growth wherein RIGHT lamina is atrophied and LEFT lamina is hypertrophied; either of which allows ENTIRE VERTEBRA to be subluxated according to a TRUE PRI rule except for spinous process which distorts itself to a FALSE PRI rule.

(See Illustrations No. 75, 76 and 77.)

If head is low on right

atlas and axis are low on right

and axis spinous process is to RIGHT of median line, we will, at times, find a cervical scoliosis TO LEFT in a left rotatory scoliotic adaptative curve. The kink in adaptation to curve is what makes spinous process of axis appear TO RIGHT of median line.

If head is low on left

atlas and axis are low on left

and axis spinous process is to LEFT of median line, we will, at times, find a cervical scoliosis to right on a right rotatory scoliotic adaptative curve. The kink in adaptation to curve is what makes spinous process of axis appear TO LEFT of median line.

Where head is low on LEFT

atlas and axis are low on RIGHT, and

spinous process of axis is LEFT of median line

look and see if balance of cervical region is curved adaptatively and compensatingly to LEFT. If they are, it is a PLI axis true subluxation, assuming atlas is not otherwise the major.

(Illustrations 313 and 314 are of the type just described.)

In the reading of A-P and Lateral spinographic films, the PRI True, PLI True; PRI False, and PLI False are easy, because

all one needs do is to follow the rules by asking himself these questions:

Which side is the head low on
 is the atlas low on
 is the axis low on
 is the spinous process on in relation to the median line?

When you get those facts, you have one of the four axis subluxations. There does exist a small minority of cases that come within a "border line", where it is difficult to say which side is low. These will require detailed study.

Occasionally you may decide you have an actual "PI" spinous process that is neither left nor right of median line. A study of even such a case will prove that skull, atlas, and axis are slightly lower on one side than on the other, even tho that be little. In such case, follow rule for adjustment by laying head face-down on side that is low, favoring adjustment from opposite side, giving some but more laterality in the adjustment direction.

(See Illustrations 78, 79, 80 and 81.)

The objective of the torqued adjustment, in either of the above cases, IS TO UNTORQUE THE TORQUED SUBLUXATION. This requires:

head low on left
 atlas low on left
 axis low on left

and axis spinous process to RIGHT or LEFT of median line must be raised superior ON LEFT. To do this requires that torqued subluxation, either TRUE PRI or FALSE PRI, must be untorqued by adjustment FROM PRI IN BOTH INSTANCES; therefore both conditions would be listed as tho both were PRI subluxations. If spinous process is LEFT of median line, then torqued subluxation must still be untorqued by adjustment FROM PRI; therefore spinous process being to LEFT is a FALSE position of spinous process but a true position of the vertebral subluxation.

Where head is low on right, atlas and axis are low on right, the axis spinous process automatically must turn itself to left. (If you have an atlas and axis in your hands, try this simple test.) The head, atlas, and axis being low on right, produce a

torqued subluxation of either atlas or axis. This torqued subluxation adaptatively forms a usual left cervical scoliosis. This left cervical scoliosis becomes the major adaptative curvature to major subluxation immediately superior to it. If you possess an A-P 36 inch full-length film, study will prove that there is also a usual right dorsal scoliosis as well as a left lumbar scoliosis; each becoming less as you proceed lower. Correspondingly, pelvis is tipped high on right and low on left; with a correspondingly shorter leg on right than left. Adjustment of torqued atlas or axis, automatically corrects all curvatures inferior to it, levels pelvis, and corrects what appears a variation in lengths of legs.

Where head is low on left, atlas and axis are low on left, axis spinous process automatically must turn itself to right. The head, atlas, and axis being low on left, produce a torqued subluxation of either atlas or axis. This torqued subluxation adaptatively forms a usual right cervical scoliosis. This right cervical scoliosis becomes the major adaptative curvature to major subluxation immediately superior to it. If you possess an A-P 36-inch full-length film, study will prove that there is also a usual left dorsal scoliosis as well as a right lumbar scoliosis; each becoming less as you proceed lower. Correspondingly, pelvis is tipped high on left and low on right; with a correspondingly shorter leg on left than right. Adjustment of torqued atlas or axis automatically corrects all curvatures inferior to it, levels pelvis, and what appears a variation in correct lengths of legs.

(See Illustrations 145 to 172 which portray adaptative or compensatory vertebral column abnormal curves as shown in full length single exposure spinographs.)

The above are general rules and help to guide us to ascertain which side of head, atlas, and axis are low; but the rule is not absolute. I have seen spinographs which are opposite to above stated rules. Other cases do not portray curves other than normal. It can be followed only along general lines.

One thing that will help in reaching these definite conclusions is to establish level or plane lines in your mind's eye; the level or plane line of the relation of the skull to its atlas; the level or plane line of the atlas in relation to its skull AND axis; the level or plane line of the relation of the axis to its atlas superior and 3rd cervical inferior. These level or plane lines, naturally,

are purely as they strike the eye. They do not exist in reality although there is a reality to their existence. They can be established on lateral as well as A-P views. It is never necessary to go below the 3rd cervical in thus establishing level or plane lines, except for purpose of comparisons of perpendicular lines of the entire cervical region with the kinks, wrenches, torques, or twists that exist between any named.

Every twist, kink, wrench, or torque has two choices, either in listing for subluxation or in direction for adjustment. The peculiar nature of the atlas in rotation of head and itself upon the axis, with head rocking forward or backward; and axis with its odontoid process in the neural canal, with the atlas rotating around it; makes either one the focalized point for the major in this region. At first it takes careful study to know which of the two is greater, in distortion, than the other.

In instructing on this question, I find students who know intimately the natural, normal position of the relations between head, atlas, axis, and 3rd cervical, have little difficulty in visualizing the abnormal and unnatural when spinographs are shown and enlarged upon a screen. Without this foundation, it is difficult for the average Chiropractor to know whether what he is looking at is proper or improper, normal or abnormal, natural or unnatural.

Sometimes the atlas is THE one more out of natural relationship than the axis. Sometimes it is the axis. The majority are axes. (See table in this article). But it is important to discriminate.

(Illustrations 3, 4, and 5 have been taken to show as nearly normal of this region as is possible with external specimens not in the living or recent state.)

In a study of specific torqued subluxations, in this major region where they can only occur, THE MAJORITY of atlas torqued subluxations are anterior and superior, either right or left; of THE MAJORITY of axis subluxations that are inferior, THE MAJORITY will be right. This may be due to the fact that THE MAJORITY of people are right handed. I have yet to analyze a superior axis, judged solely by the position of the vertebra as a whole.

The torque subluxation may be between

- occiput and atlas
- atlas and axis
- axis and 3rd cervical

but torque adjustment will be given

- on atlas for torque subluxation between occiput and atlas, or between atlas and axis
- on axis for torque subluxation between atlas and axis, or between axis and 3rd cervical.

The torque adjustment will ALWAYS be EITHER ATLAS OR AXIS. In three years of study on this particular phase of our problem and its solution, and an observation of several thousand cases, I have yet to see ONE CASE wherein any "adjustment" was necessary on occiput or 3rd cervical; or any other vertebra inferior to third cervical. The occiput or 3rd cervical, at best, would be an INDIRECT method in an attempt to correct the DIRECT torque. The closer one allies himself TO atlas or axis, to correct torque between these two or contiguous one superior or inferior to these two, THE MORE DIRECT his approach. The torque involves INTER-MAGNUM-ATLAS FORAMEN and ODONTOID PROCESS. The farther one removes himself FROM THE TWO VERTEBRAE THAT INVOLVE either, the more indirect the approach is and the less effective his "adjustment" will be.

BORDER LINE CASES

Some cases have marked position of head, appearing LO or HI. A cursory glance of position of head and atlas gives some appearance of its having an atlas wedge-side-slip subluxation. You draw the atlas plane lines on A-P view and instead of proving a wedge they are parallel, thus denying the primary element of it being a wedge-side-slip. Lateral view exhibits anterior arch either superior or inferior, either minor or markedly so. To have a locked-torqued subluxation it must have THREE directions. In this situation there are but two, viz.: AS or AI—no R. or L.

Not being an atlas, it must be an axis. A-P view shows head, atlas and axis low on R. or L. and gives us the rule of axis subluxation, true or false.

This raises the question: what about anterior arch of atlas being superior or inferior, little or much? Can atlas be subluxated with only TWO directions without having a wedge-side-slip?

By comparison of positions of atlas and axis, A-P and lateral views, atlas shows TWO directions; axis shows THREE. The necessity of a subluxation having THREE directions demands that axis be adjusted rather than atlas.

Here, then, is the existing border-line case.

(See discussion re border-line cases, Chapter VIII, under "A Vertebral Subluxation Must Have Three Directions.")

In seeking to locate THE subluxation, betwixt atlas or axis, we seek THREE directions. If atlas exhibits only TWO and axis exhibits THREE, this excludes atlas and includes axis. This makes atlas a border-line case.

Occasionally atlas, lateral view, appears level, anterior arch being neither superior nor inferior. In such a case atlas, A-P view, will usually have its plane lines parallel to each other also. This further evidence throws the case into axis rule.

When atlas IS a wedge-side-slip in a L. LO or R. LO the head, atlas and axis WILL BE low on THAT side. IF you apply axis rule on a LO atlas wedge-side-slip, you will drive wedge more to the apex side and make the wedge-side-slip of atlas worse. DO NOT ADJUST AXIS TO THE SIDE OF AN ATLAS LO WEDGE-SIDE-SLIP.

Occasionally, with R. or L. HI, very act of head being raised on one side APPEARS to LIFT atlas FROM axis and separates the articulations between creating a space observable in spinographs. Likewise, at same time, very act of head being lowered on opposite side APPEARS to COMPRESS atlas UPON axis and squeezes articulations between permitting no space observable in spinographs. Altho not a regular occurrence, these facts do not change atlas or axis rule. It does create a distinctive difference which establishes a border condition which DOES make adaptative and compensatory conditions different than in other more usual subluxated articulations between atlas and axis.

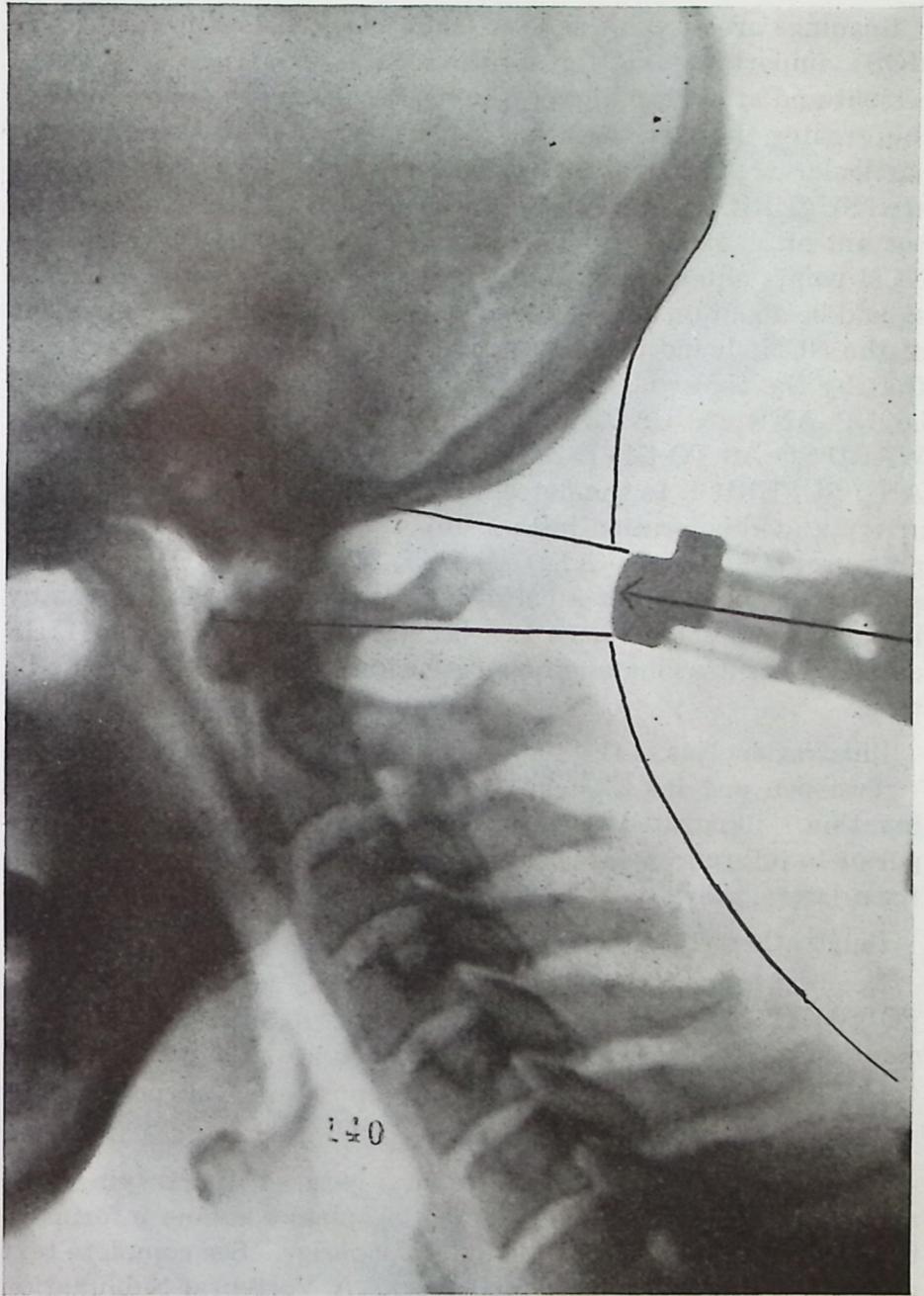


Illustration No. 140

Illustration No. 140.

Readings are of value as they incline from below upward. The MOST important single place to read interference is between occiput and atlas; the higher, the more nerves—the more motion, the greater the interference. Many Chiropractors, reading this particular area, direct their NCM on a level plane and miss the area SUPERIOR TO ATLAS, thereby missing THE one most important of all readings. Beginning at the base of the neck, the NCM points anterior and inferior. At the middle of the neck you should be about on a level. As you glide superiorly, the direction of the NCM should be superior and gradually incline superior so that by the time you reach the base of the occiput, you should be UP AND IN UNDER IT, DROPPING THE NCM DOWNWARD SO AS TO GIVE A DIRECTIONAL VALUE, UPWARD AND SUPERIOR to the detectors as indicated in drawing. After arriving at this location in that direction, give a slightly heavier pressure TO GET IN AND UNDER—THEN HOLD until you see if there is or is not a backward return of the needle. Many important cases have been lost because of carelessness to THIS detail. Note drawing and how extension lines indicate area to be read.

Illustration Nos. 141-142.

Two pen and ink sketches to illustrate a rotation atlas subluxation. Illustrated because difficult to spinograph from superior to inferior, or inferior to superior altho observable in part, from lateral views.

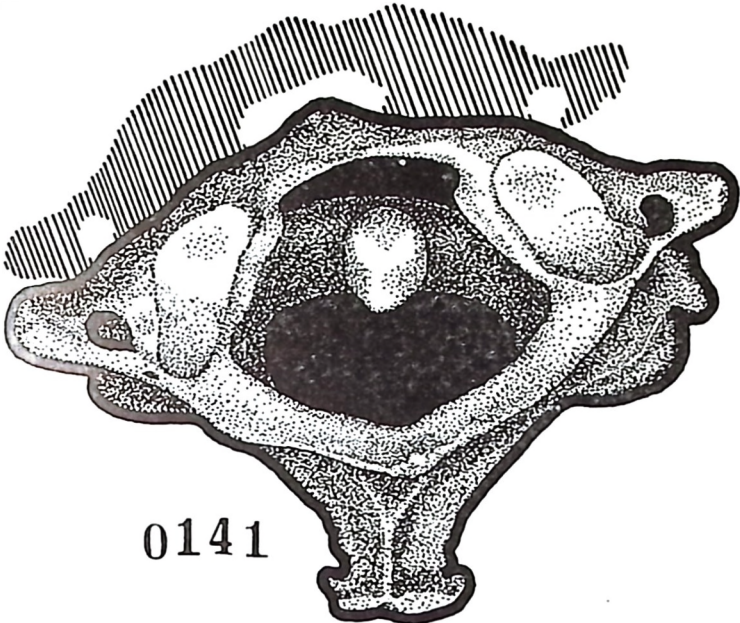
Illustrations 143-144.

Reading spinographs with large magnifying glass. TENDS TO give third dimension value. In contrast to caliper measurement method. Get far enough away to secure perspective values.

143 is general, while 144 is a close-up of same purpose.

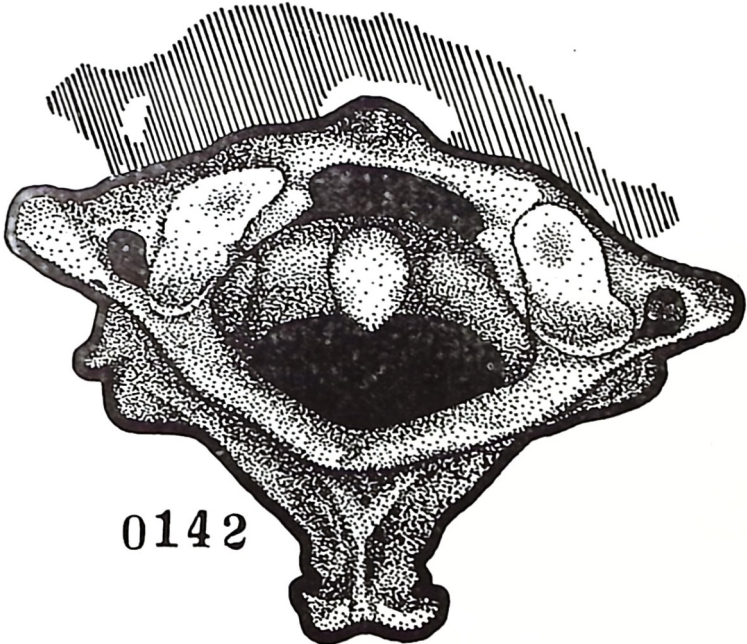
Illustrations 145-172.

Full length, 36 inch spinographs, reduced, portraying the adaptative or compensatory curves of spinal columns inferior to the wedge-side-slip atlas subluxation superior. See complete text matter on this in Chapter VII under "A Vertebral Subluxation Must Have Three Directions."



0141

Illustration No. 141



0142

Illustration No. 142

Illustrations No. 173-174.

A BEFORE AND AFTER case of correction of adaptative or compensative curves corrected by HIO adjustments exclusive process of deduction.

Case: Mr. Sandel. Chiropractor: Harry L. Sanford, D. C., 5319 Greenwood Ave., Seattle, Wash. First spinograph taken June 1, 1932, at Santa Barbara, Calif. Lateral showed solid spine. No separation between segments. Left curvature in dorsal; right curvature in lumbar. Odontoid process of axis was at least two-thirds posterior into neural canal.

Major: Atlas AIL. This was all that was adjusted. Recoil adjustment only. Eleven adjustments in six months. Second spinograph taken November 1, 1932. Dorsal curvatures nearly all gone. Lumbar curvature practically gone. Rotation completely eliminated. Second picture showed a decided separation between axis and atlas. Previous to going to Santa Barbara, case had "taken adjustments" for eight years under meric system and getting worse. To see a person, he would be compelled to incline his knees forward, settling his body in a sitting posture. Today he stands straight. Height is 4 inches taller than June 1, 1932.

Illustrations No. 175-176.

A BEFORE AND AFTER case of correction of adaptative or compensatory curves of cervical region, corrected by HIO adjustment exclusive process of deduction of fact. The case was in the practice of F. H. Seubold, D.C., Chicago. Case was given 5 adjustments in a period of three months. Nothing else was done, given, or taken during that time.

(See complete text in Chapter VII under "A Vertebral Subluxation Must Have Three Directions.")



Illustration No. 143



Illustration No. 144

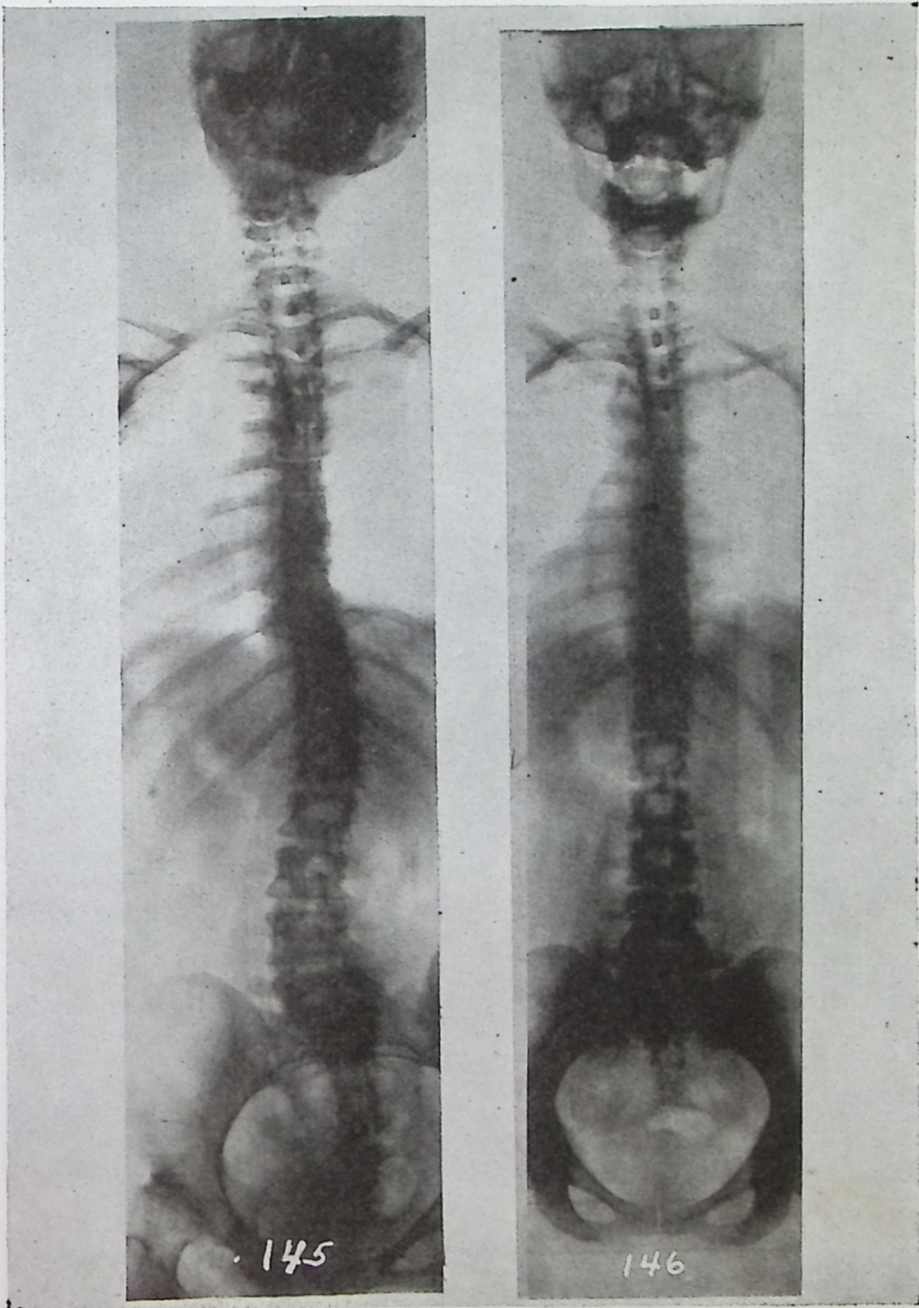


Illustration No. 145

Illustration No. 146

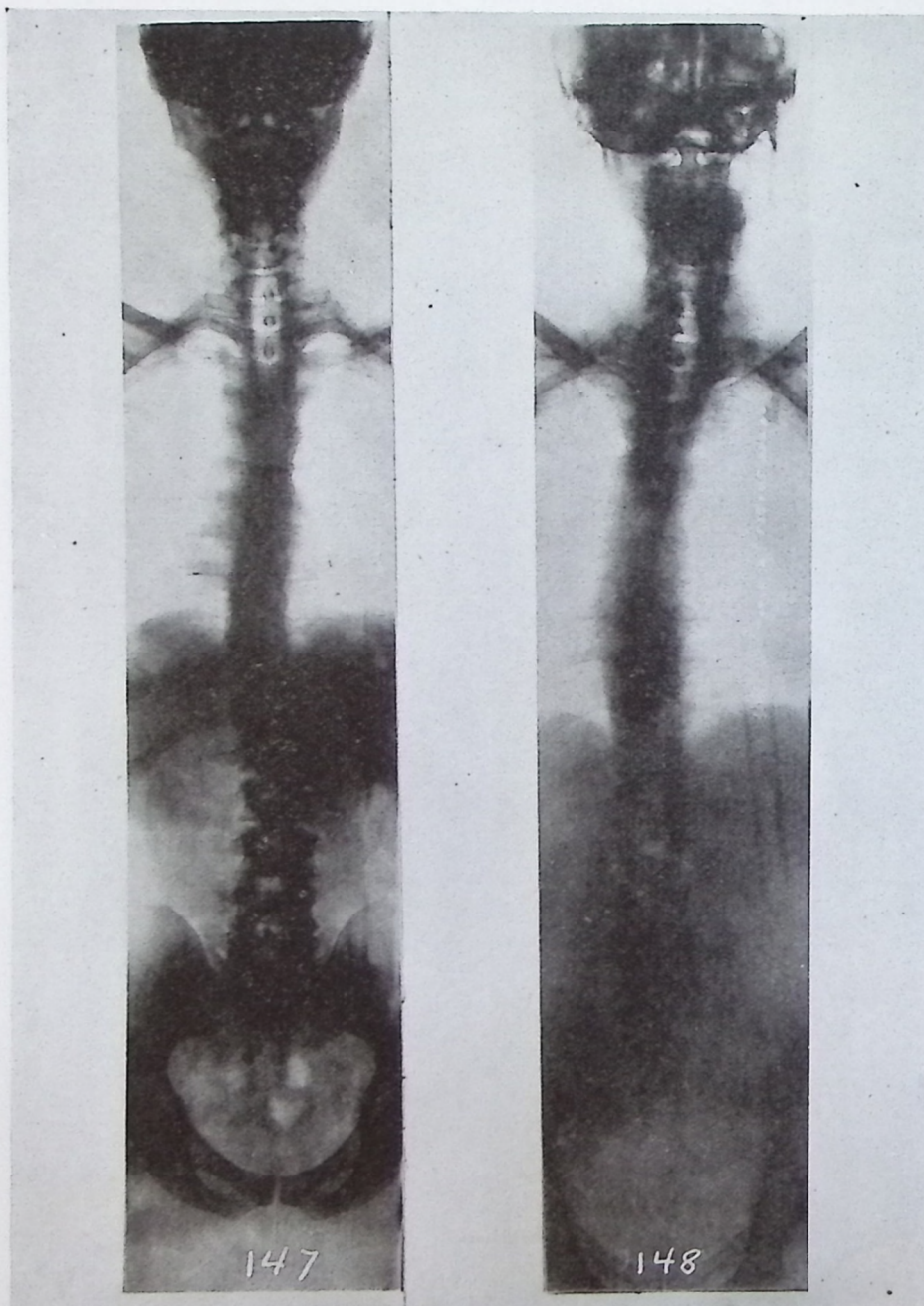


Illustration No. 147

Illustration No. 148

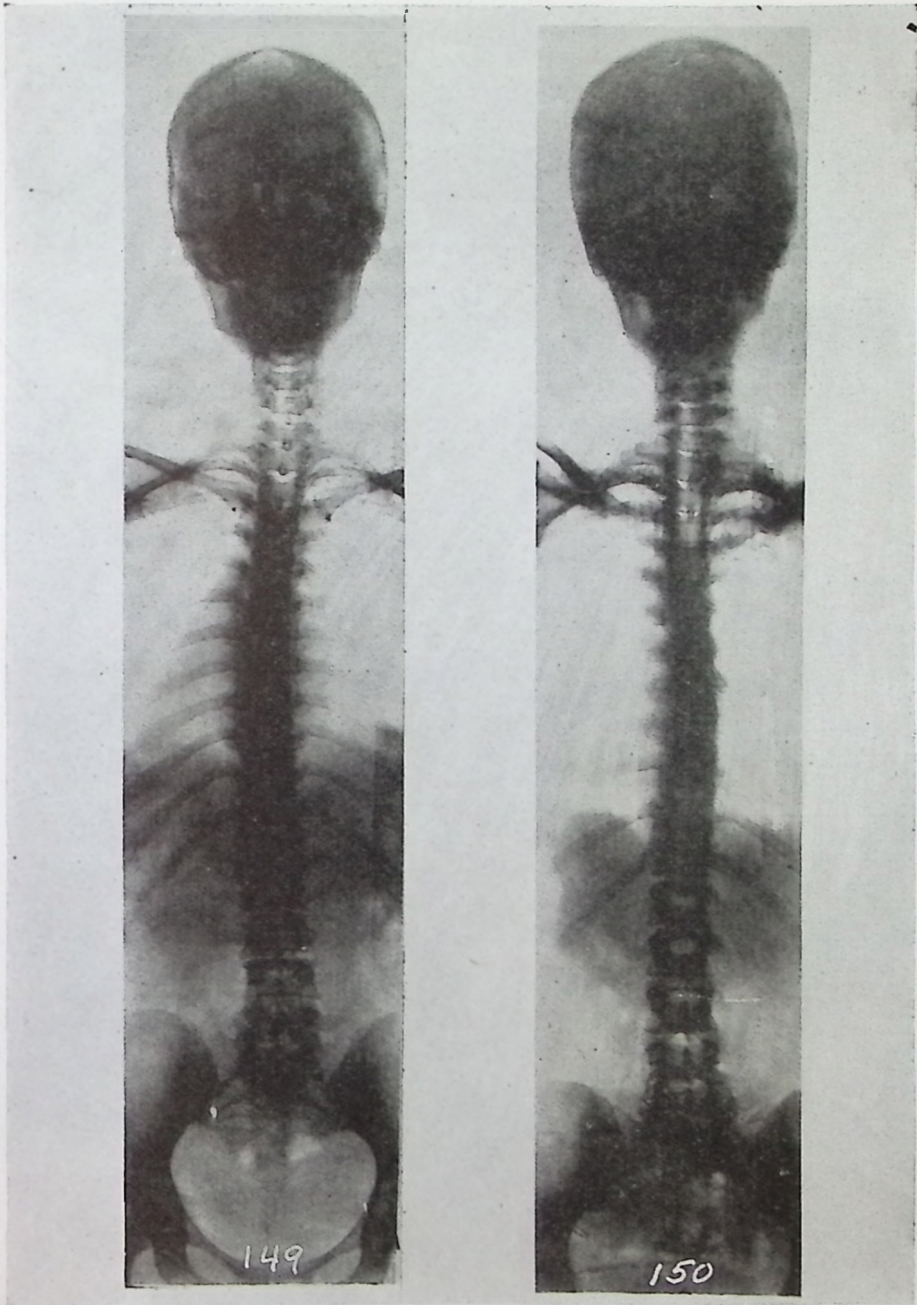


Illustration No. 149

Illustration No. 150

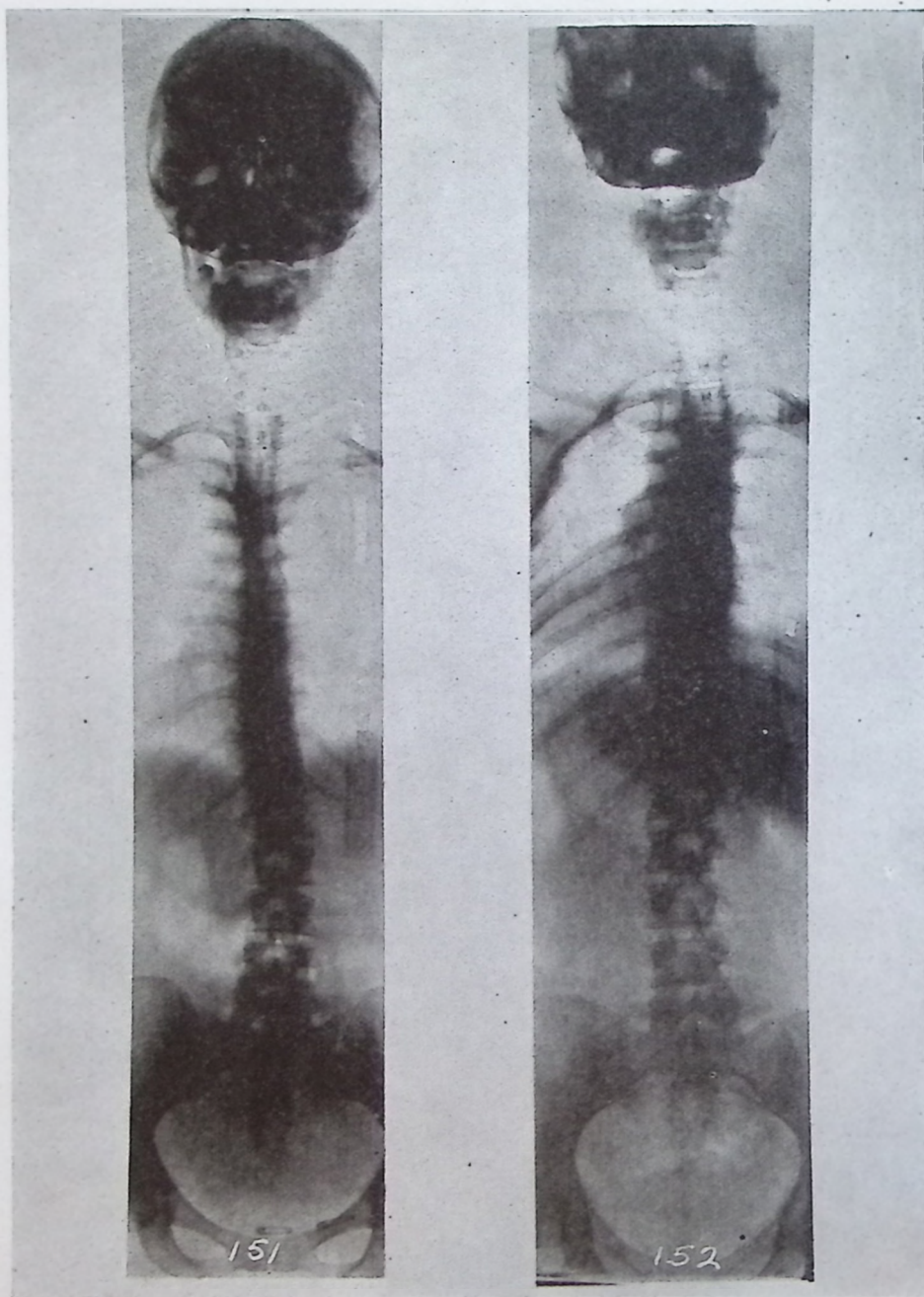


Illustration No. 151

Illustration No. 152

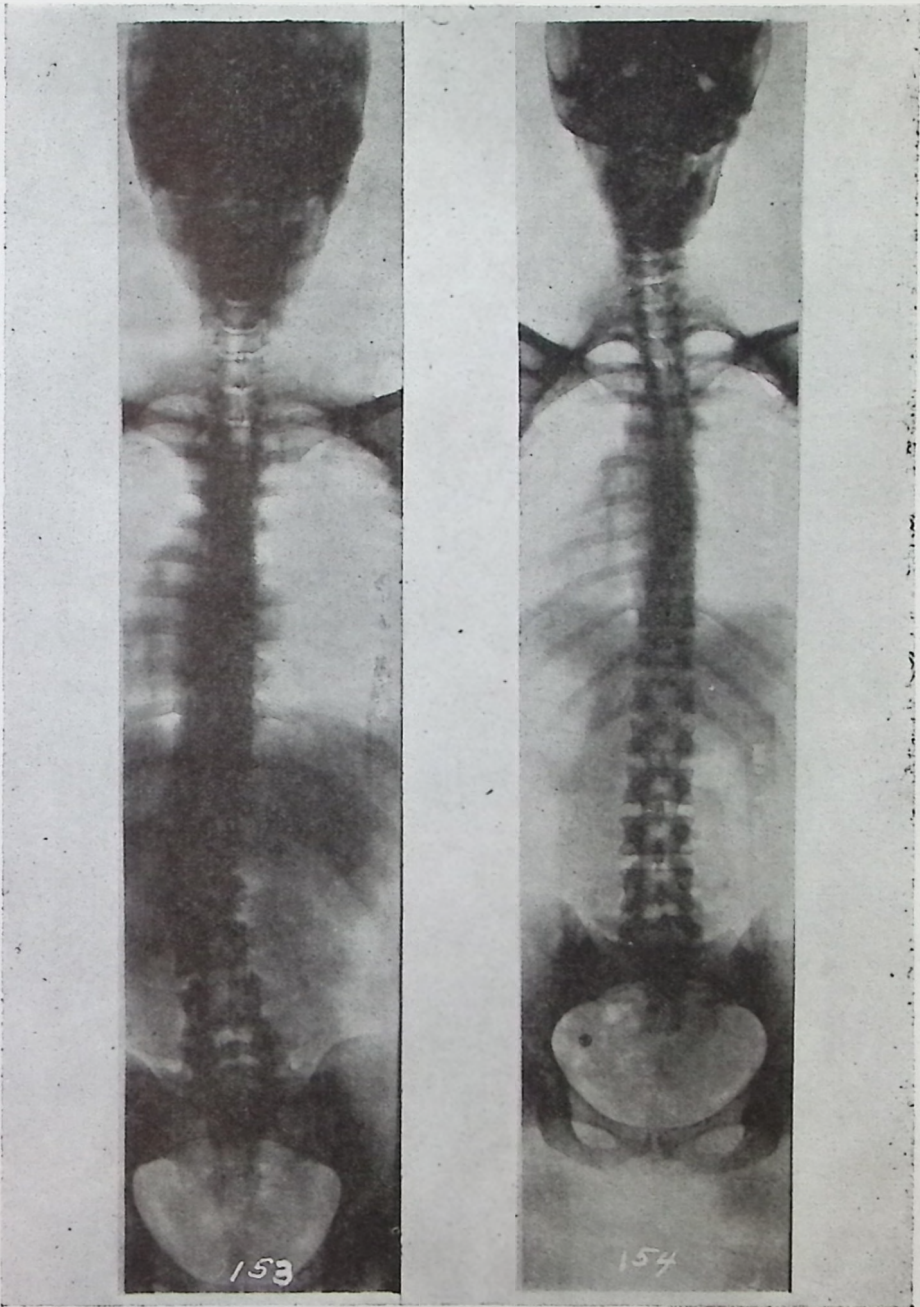


Illustration No. 153

Illustration No. 154

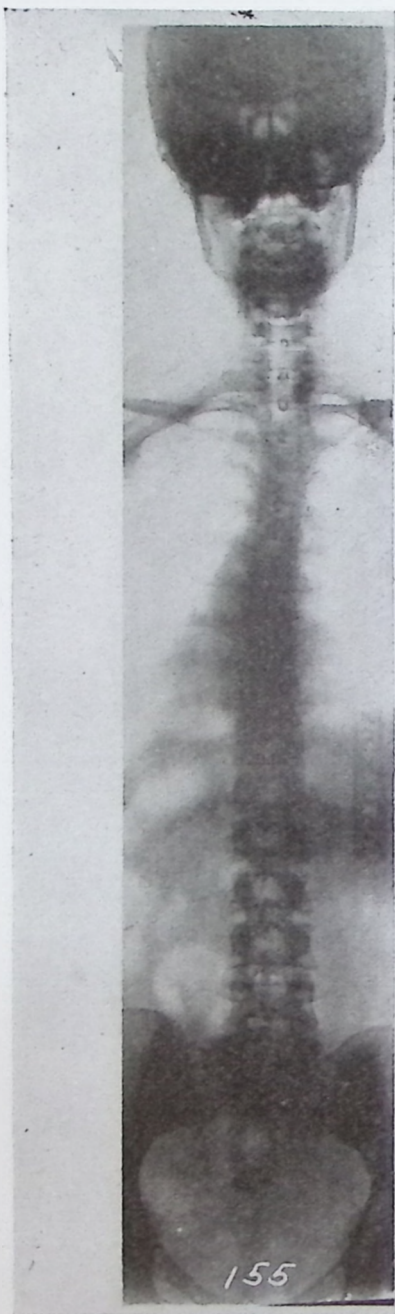


Illustration No. 155



Illustration No. 156

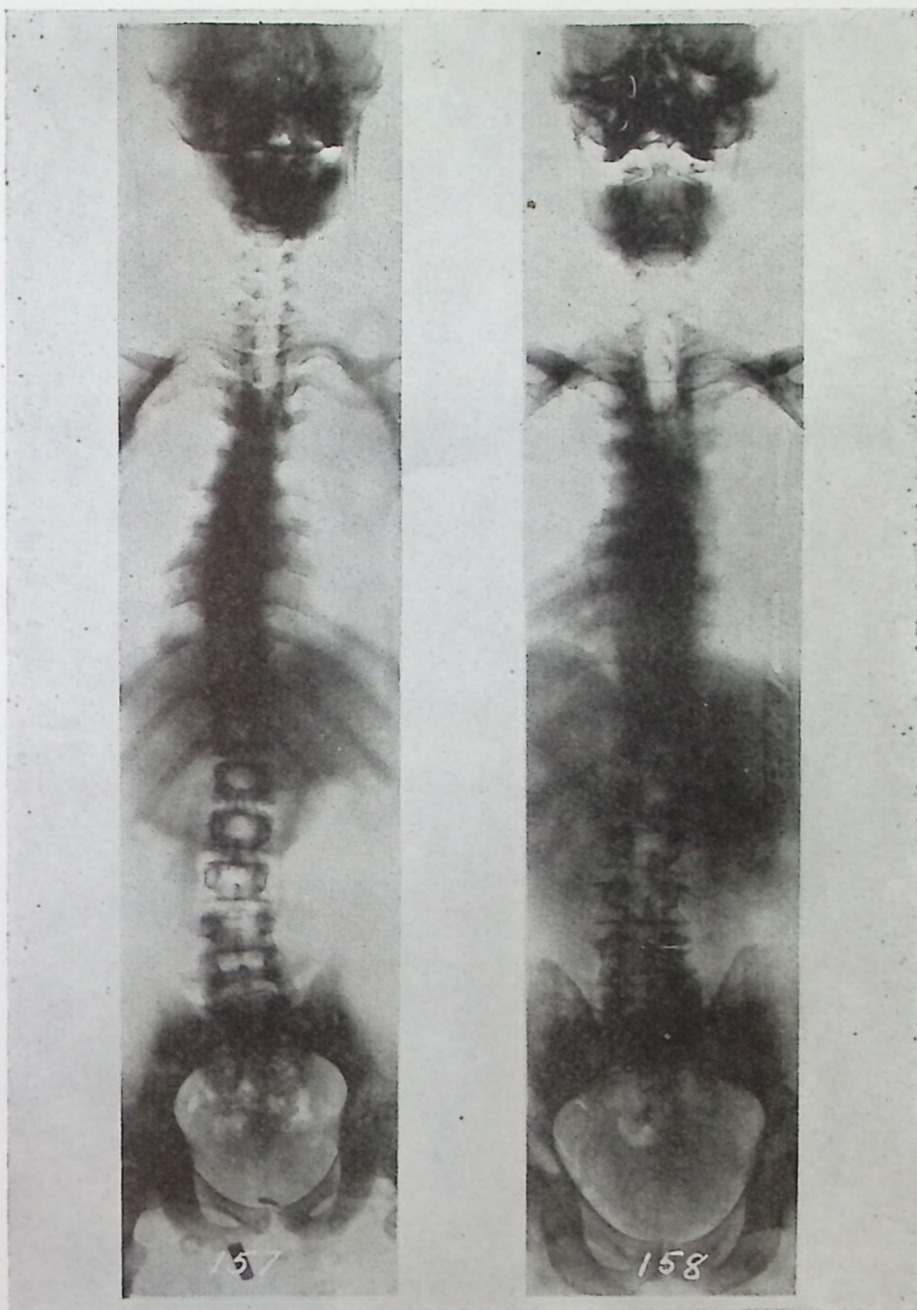


Illustration No. 157

Illustration No. 158

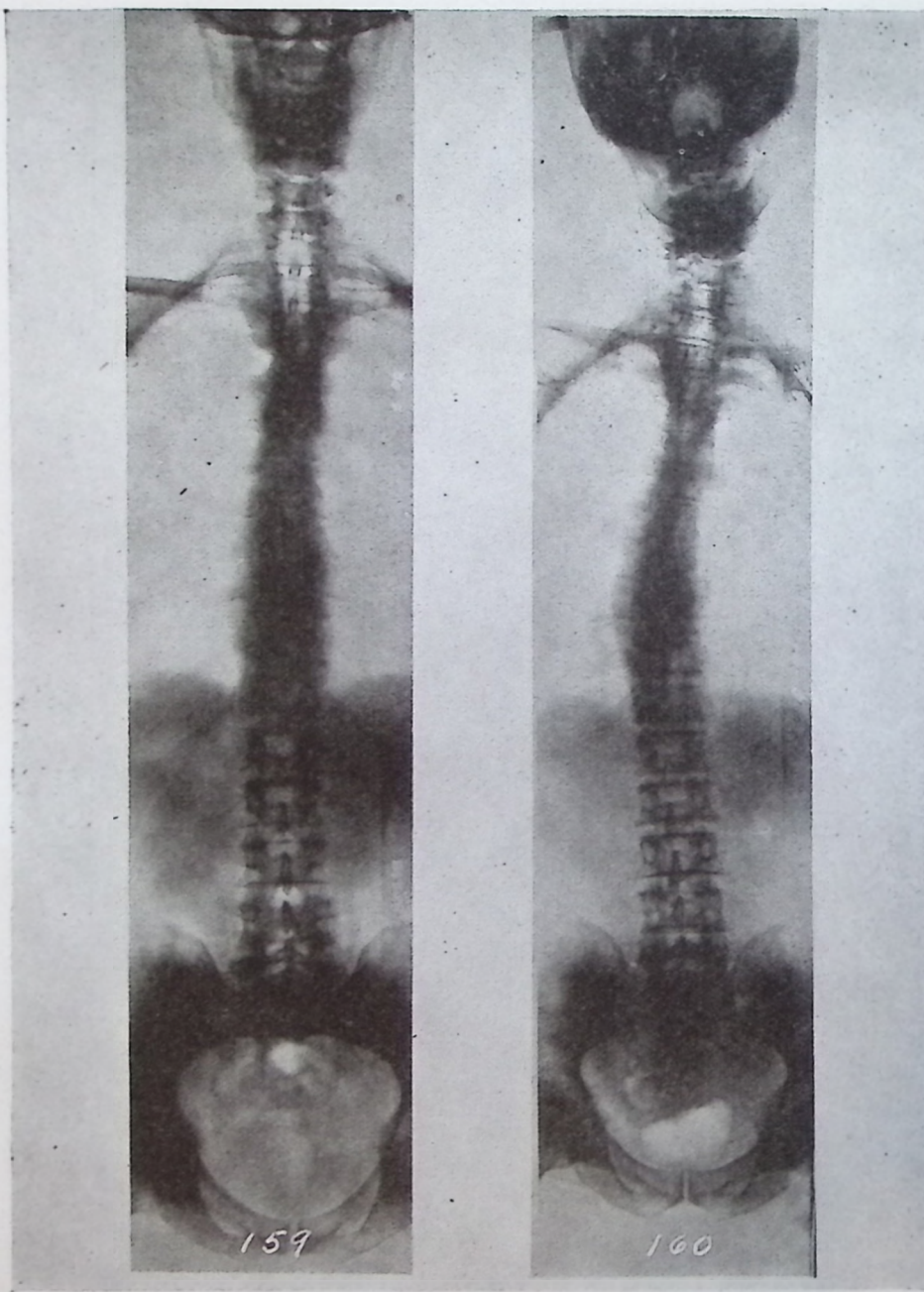


Illustration No. 159

Illustration No. 160

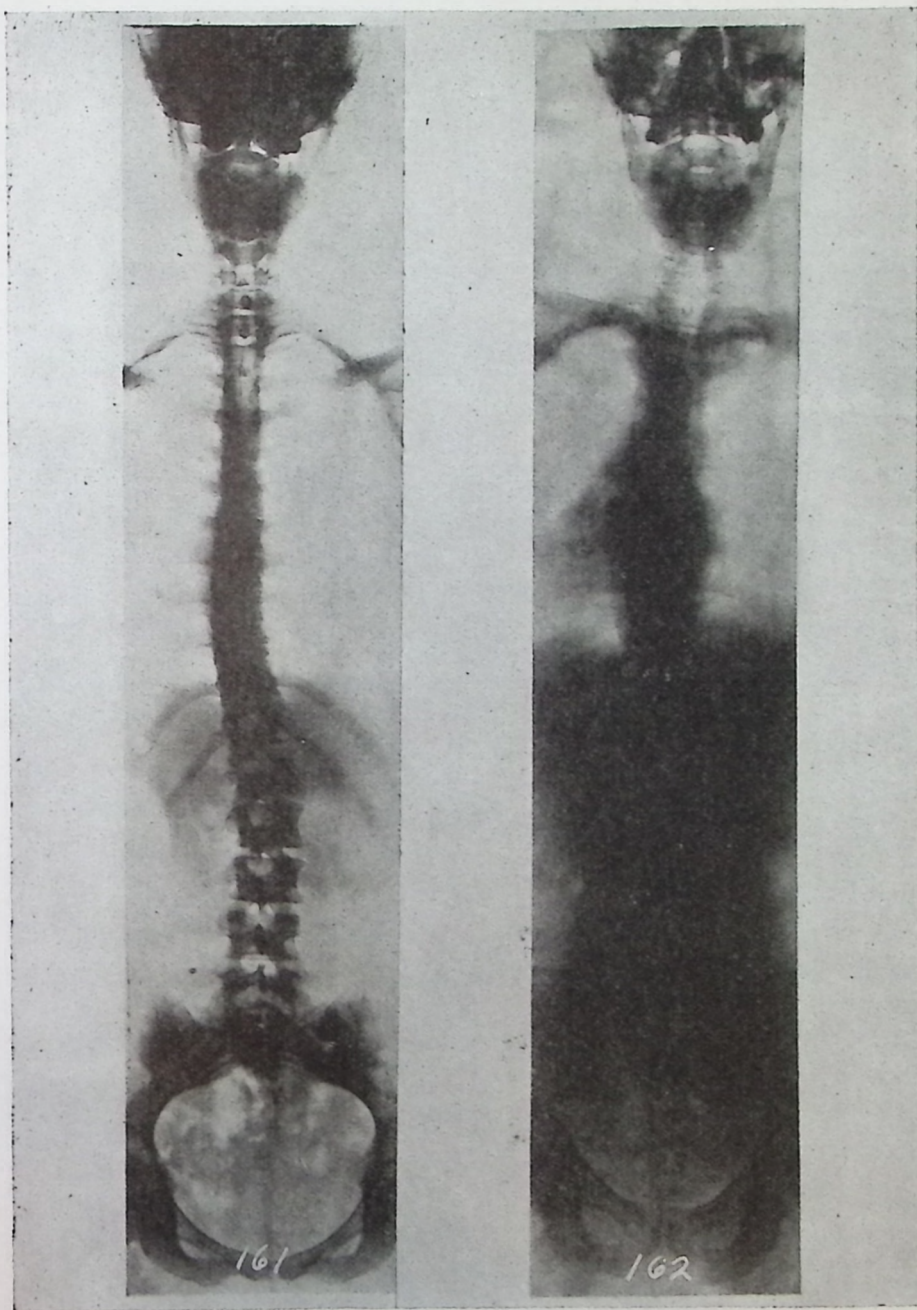


Illustration No. 161

Illustration No. 162

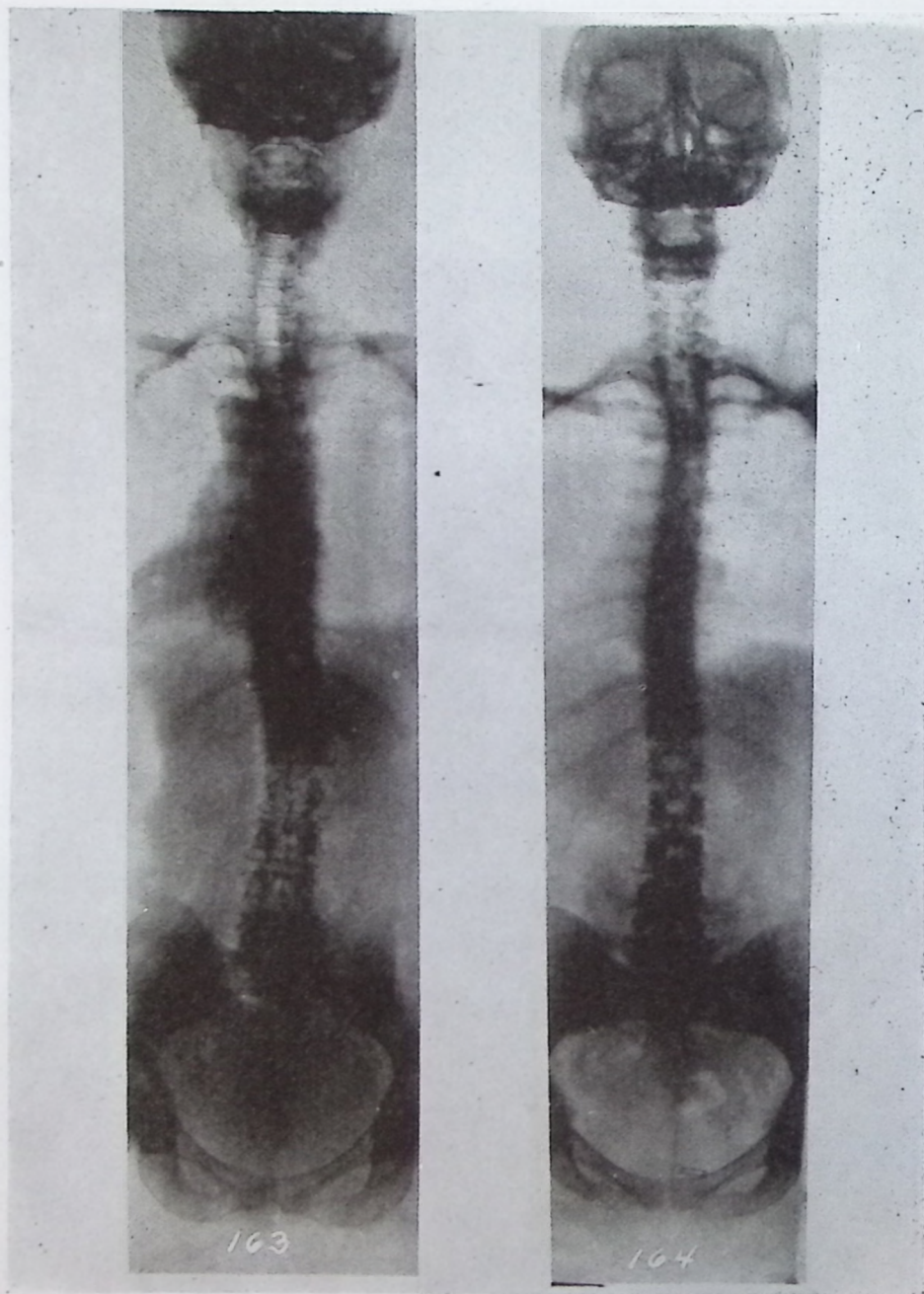


Illustration No. 163

Illustration No. 164

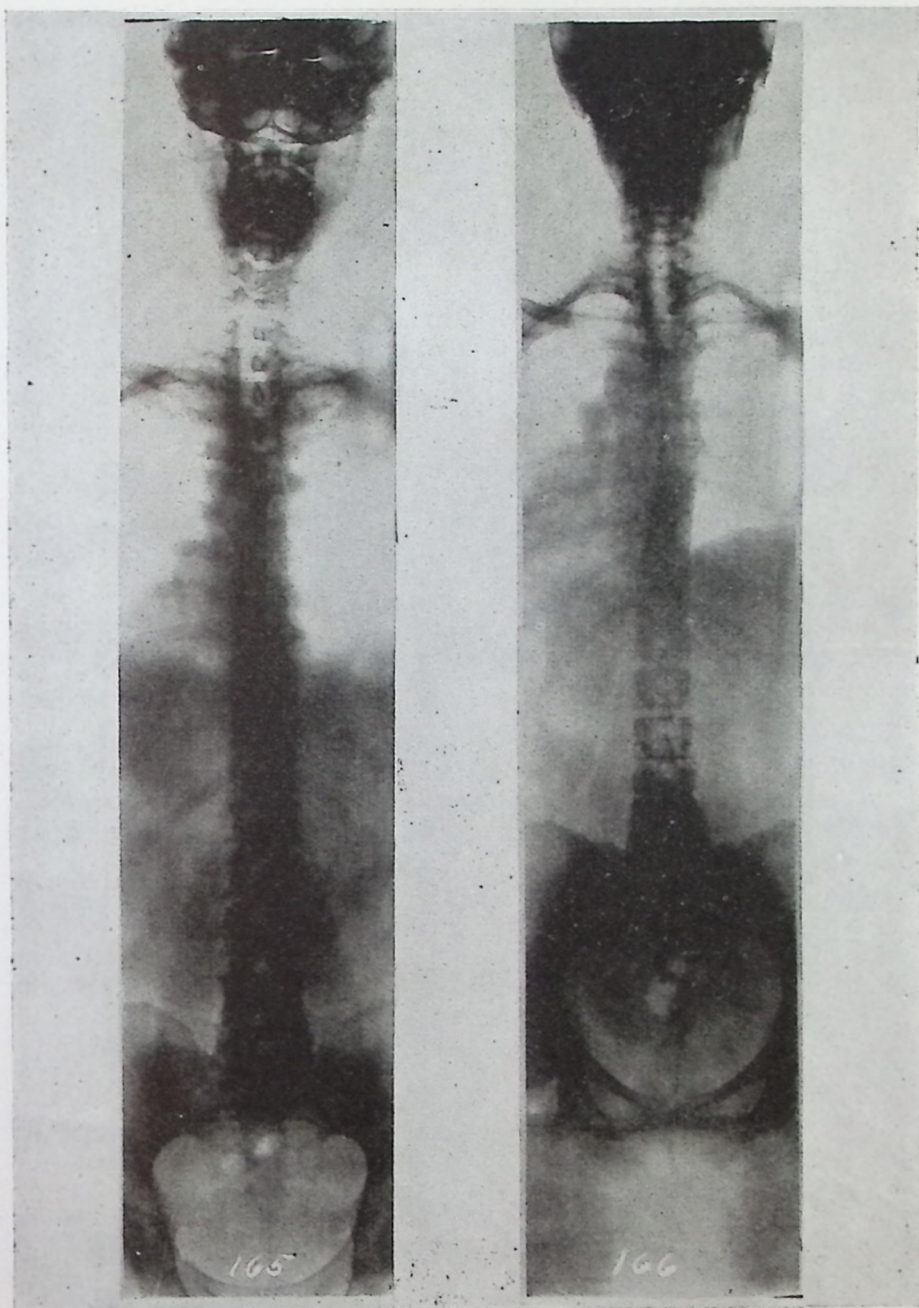


Illustration No. 165

Illustration No. 166

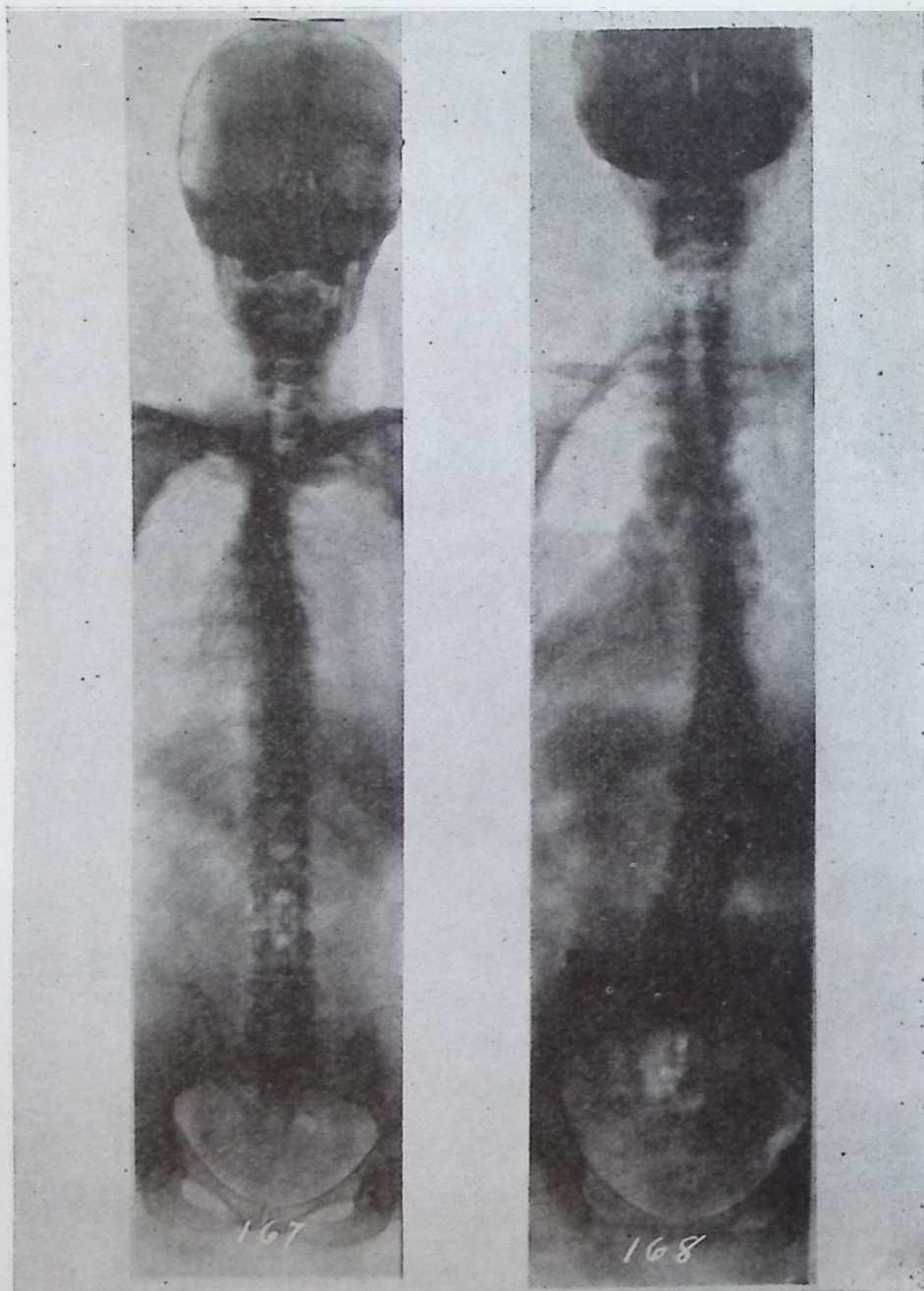


Illustration No. 167

Illustration No. 168

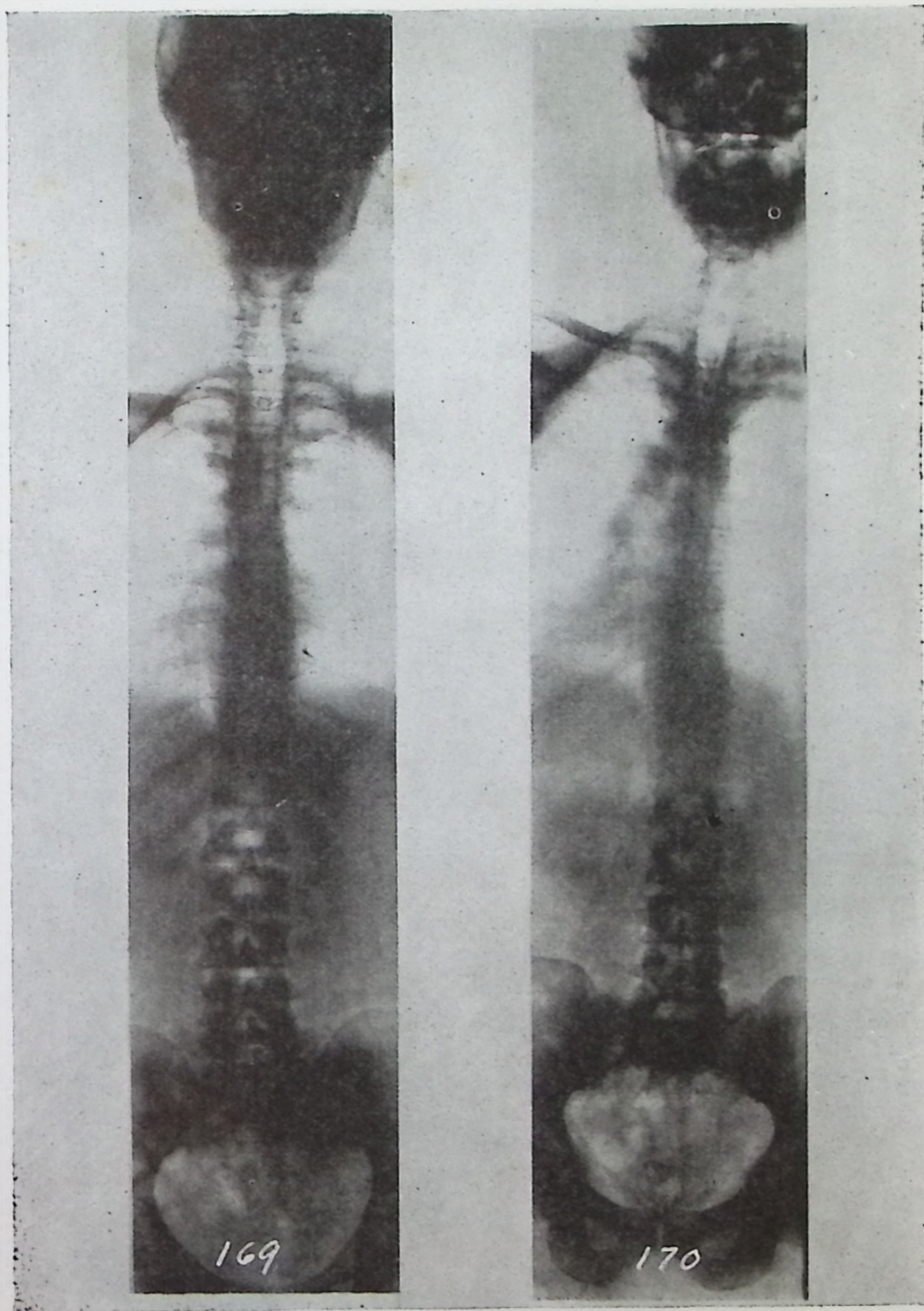


Illustration No. 169

Illustration No. 170

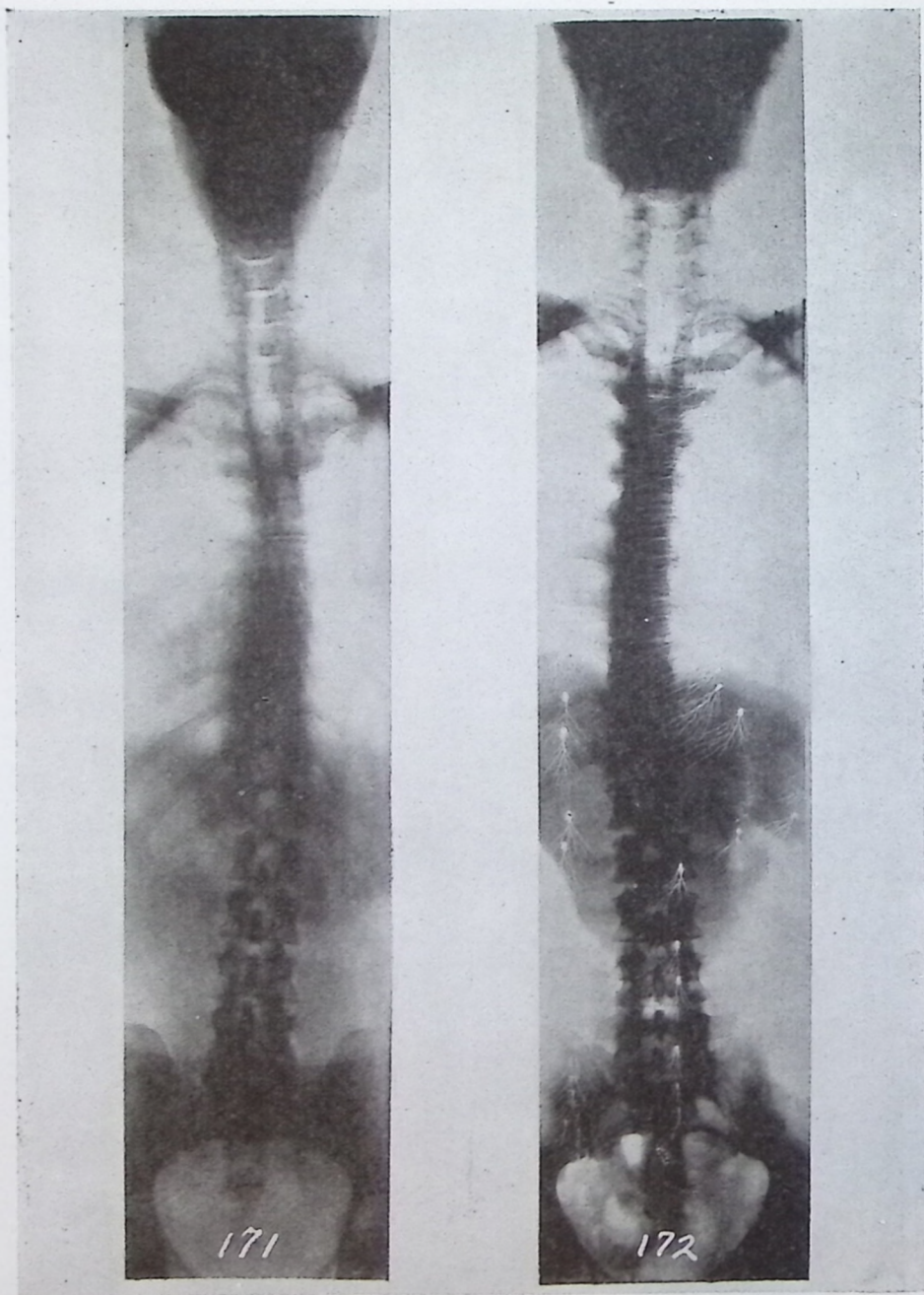


Illustration No. 171

Illustration No. 172



Illustration No. 173

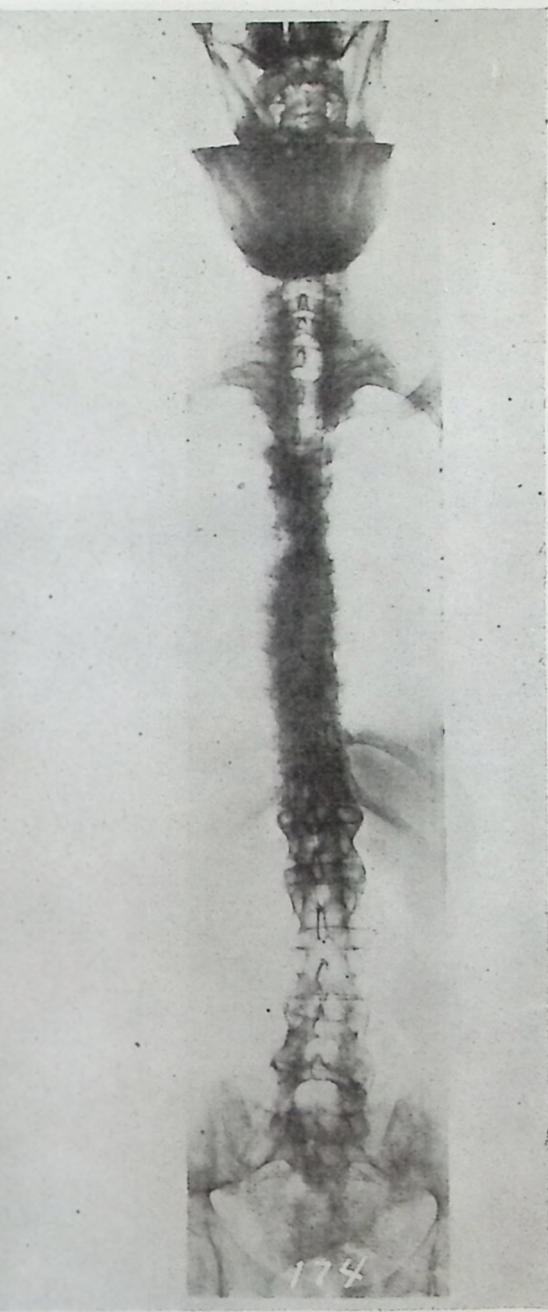


Illustration No. 174



Illustration No. 175



Illustration No. 176

CHAPTER XII.

THE SPECIFIC ADJUSTMENT

WHAT DO WE MEAN BY "HOLE IN ONE"?



VARIOUS opinions are held as to what is meant by the term "HOLE IN ONE." It is the WHERE, WHEN, AND HOW in a more EXCLUSIVE interpretation OF THE CHIROPRACTIC PRINCIPLE with a BROADER application of THE CHIROPRACTIC PRACTICE than heretofore. The difference between knowing WHERE, WHEN, AND HOW, and not knowing, makes the difference between success and failure.

1. It refers to the NCM No. 2 location of interference, rather than the mental determination by digital palpation or history of symptomatology or pathology or other diagnosis.
2. It includes the SPGH determination of position, rather than fingers-mental deduction.
3. It prefers ONE subluxation occasionally, rather than an average of 6 to 10 or all of them regularly and daily.
4. Its record suggests one multiple interference rather than many local interferences scattered up and down spinal column.
5. Its results justify one major, rather than many minors, or one major and several minors.
6. One ADJUSTMENT ("the adjustment with that extra something") of specific character, at one place, rather than various diversified technique "adjustments" at multiple places, daily.
7. One ADJUSTMENT, one place, having a staying-put value ("the adjustment with that extra something") covering several days or weeks; rather than many "adjustments", many places, daily, few of which stay put 24 hours.
8. One continuous flow of mental impulses, covering a continuous flow for days or weeks; rather than many local flows, flowing spasmodically, temporarily — pressures of which recur.
9. It presents a marked reduction in time necessary to re-

covery, rather than drag out a case for months or years.

10. It proves that we can ADJUST less frequently ("the adjustment with that extra something") but more certainly, to consistently get case well once and for all; rather than jab away at many places daily, to get them well, sick again, well again, sick again—maybe to ACCIDENTALLY get well or leave them permanently sick; where health was AN ACCIDENT in spite of us rather than because of us.
11. The normal right mixture of all above tells when not to ADJUST (the adjustment with that extra something); that a daily "adjustment" is injurious, and that it is actually dangerous to "adjust" so many places so frequently, when none was needed, demanded, or justified.

ALL SUBLUXATIONS ARE MISALIGNMENTS, BUT NOT ALL MISALIGNMENTS ARE SUBLUXATIONS

If SUBLUXATIONS occur, more specifically in cervical region, then what are those conditions which we find below, which we formerly construed as SUBLUXATIONS?

The hour has arrived when a distinction must be made between a misalignment that IS a subluxation, and a misalignment which is ONLY a misalignment; between a SUBLUXATION which IS occluding the foramen, producing pressure upon nerves, and does interfere with local as well as a multiplicity of transmissions having various exits below itself; and some vertebra which is out of alignment in relationship with ones above and below, but does not and is not occluding a foramen, producing pressures upon nerves, and is not the source of interference with transmission because thereof.

PALPATION will reveal no difference between the misalignment of vertebrae below, which are MISALIGNMENTS, and those above which are SUBLUXATIONS, for they are all out of alignment and all FEEL like SUBLUXATIONS. SPINOGRAPH will reveal no difference between misalignment of vertebrae below and those above, for they are all out of alignment and all LOOK like SUBLUXATIONS. To all ordinary HUMAN tests, that vertebra which is out of alignment and is NOT a SUBLUX-

ATION, and that vertebra which is out of alignment and IS a SUBLUXATION, remain the same. Some means keenly different and more sensitive than our gross human range could detect with which one or ones THERE IS AN INTERFERENCE TO TRANSMISSION OF THAT SUBTLE MENTAL IMPULSE CURRENT GOING THRU. The NCM detects THAT DIFFERENCE between vertebra below which is out of alignment, which does NOT interfere with transmission, and that vertebra above which IS a subluxation and DOES interfere with transmission. It is THAT difference which tells WHERE TO ADJUST and where not to ("the adjustment with that extra something"); WHEN TO ADJUST and when not to ("the adjustment with that extra something").

If that be accepted as the standard, then SUBLUXATIONS do not occur below axis; all SUBLUXATIONS are above it. In the past, we have believed SUBLUXATIONS could occur as much in one part of the spinal column as in the other; with possible exception of 6th dorsal, 12th dorsal, and a few others. That is now subject to an amendment. I am now using SUBLUXATION in its correct Chiropractic understanding in contradistinction to the term "misalignment" which occurs with as frequent regularity below the 1st dorsal as it ever has. In years past, we have been confusing misalignments of vertebrae below 3rd cervical for SUBLUXATIONS; but because we had not learned how to separate one from the other, or separate out facts that put one in one class and the other in the other, we threw all in as SUBLUXATIONS.

Subluxations are of two kinds: those produced by a concussion of forces invading and resisting WITH VIOLENCE; and those produced by external forces such as heat (as in relaxation) cold (as in contractures) which either relax or contract muscles to the point where a subluxation can permanently occur.

Up until this year, I have said that there were three possible degrees of violence so far as effecting the body was concerned, especially in its framework and structural continuity, viz., fractures, dislocations, and subluxations. TO THESE I NOW ADD THE FOURTH: MISALIGNMENTS.

The greatest degree will produce a fracture; less than that, a dislocation; still less, a subluxation; and last and least, a mis-

alignment. MISALIGNMENTS ARE LESS THAN SUBLUXATIONS.

Until 1895, surgeons did not know man could have a vertebral SUBLUXATION without its being, in fact, a dislocation, a dislocation-fracture, or a fracture-dislocation. Since 1895, Chiropractic has taught that man could have a vertebral SUBLUXATION which was in fact less than a dislocation. Until last three years, we did not know we could have a misalignment which was not in fact a SUBLUXATION; yet would have every such appearance by palpation, spinograph, and in moving value with the hands as in an apparent "adjustment."

Up until a few months ago, it was believed you could locate A SUBLUXATION by palpation; with a spinograph; by location of tender nerves; taut fibres, or contracted muscles. None of these locate A SUBLUXATION. Any or all of these indicative guides can and will locate MISALIGNMENTS. In previous years we construed anything we palpated that was out of alignment, which later was verified by spinograph; which had tender nerves, taut fibres, or contracted muscles, WAS A SUBLUXATION.

Facts justify the conclusion that a SUBLUXATION at a superior point produces pressures upon nerve fibres which have their exits at inferior places in spinal column. These superior pressures inflame the nerve all along its path from brain to periphery. The diminishment of mental impulse supply from superior interference, even to its point of exit from spinal column and from there on to its periphery, produces tender nerves wherever they can be externally traced. It also creates taut fibres wherever they can be located. It also tends to produce prolapsed or contracted muscles and thus brings about a single or series of MISALIGNMENTS of the segments of an ALIGNED spinal column. It is obvious that no amount of mechanical work done upon MISALIGNMENT could do aught but temporarily REALIGN the segment or segments with same force and effect that any treatment would have upon any effect for the relationship between SUBLUXATION and MISALIGNMENT would be the same as SUBLUXATION of a vertebra and any other SYMPTOM in any soft tissue organ or viscus. The MISALIGNMENT is an osseous symptom to a SUBLUXATION and any attempt to

REALIGNMENT would be but a TREATMENT upon effect and not an ADJUSTMENT of cause.

It should be equally obvious that tender nerves, no matter where traced, taut fibres no matter where located, and prolapsed or contracted muscles, irrespective of territory involved, are symptoms which cannot by themselves locate SUBLUXATION or determine place of ADJUSTMENT with any more degree of accuracy than could any symptom or group of symptoms in soft tissue organs or viscera. Symptoms, regardless of whether located in soft tissues or adjacent to bony structure, must be regarded purely as symptoms and as much or as little value placed upon them as they have always deserved.

Let me cite a case. NCM reveals 8 places of peak heat readings. Palpation reveals 8 places of deviations from correct alignment by palpation. The Spinograph shows all 8 out of alignment. Tender nerves, taut fibres, and contracted muscles do exist at each of 8 places. In former days all 8 were construed as subluxations; 8 places would be adjusted. Were all 8 SUBLUXATIONS? We thot so. Oftentimes, thinking makes a thing so, until it can be successfully contradicted or denied.

Today's construction in the HOLE IN ONE is that ONE of 8 places IS a SUBLUXATION; other 7 are MISALIGNMENTS. You can ADJUST A SUBLUXATION—not a misalignment. The misalignment can be realigned, but such realignment is NOT an ADJUSTMENT because MISALIGNMENT IS NOT A SUBLUXATION. 7 misalignments have been caused by ONE SUBLUXATION; ADJUSTMENT of ONE SUBLUXATION will check out 7 MISALIGNMENTS, given time, even tho nothing be done directly upon them. In this hypothetical case, ONE subluxation was ADJUSTED; 7 misalignments would be realigned; 7 tender nerves, 7 taut fibres, and/or 7 contracted muscles will be restored. But, given time, they will realign themselves without danger of creating SUBLUXATIONS out of them in trying to realign them as misalignments.

(See further elaboration of this question in Chapter V, under sub-title "The Exclusive Process of Deduction.")

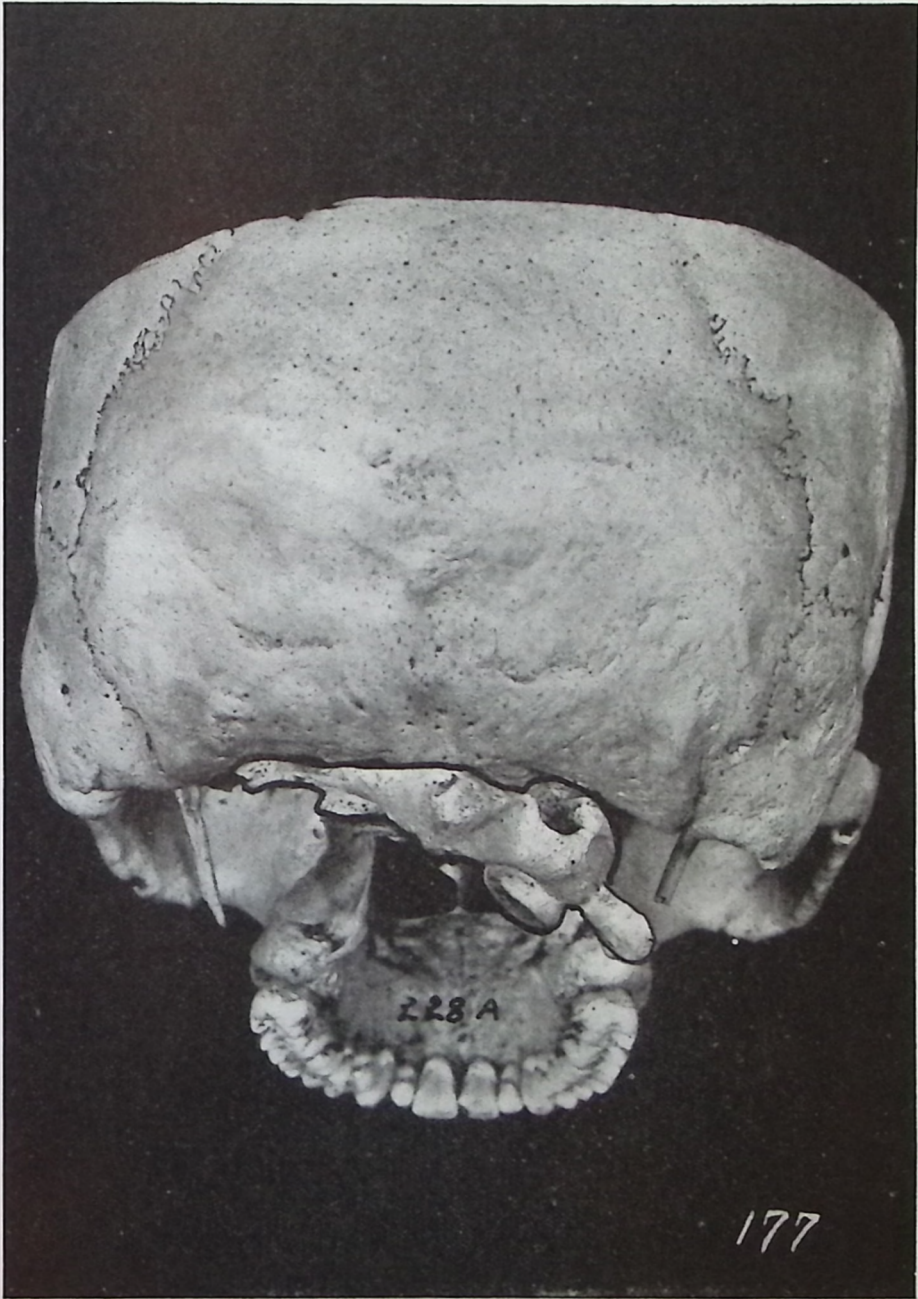


Illustration No. 177

Illustration No. 177.

Posterior view occiput and atlas. R. wedge-side-slip. Contrary to atlas rule, this atlas was side-slipped R. Atlas rule calls for point of wedge being on L. Violation of rule occurs in this specimen because of comminuted fracture of left lateral mass and right condyle. Study of specimen direct shows side-slip of R. lateral mass to R., off of R. condyle. Atlas exostosed and ankylosed to occiput.

Illustration No. 178.

Inferior-anterior view. Same specimen as 177. Not only was there present a comminuted fracture but also dislocation of atlas on L. This was possible because of crushing of left lateral mass of atlas.

Illustration No. 179.

Superior-inferior view, thru skull, showing magnum foramen, inferior to which are seen portions of left lateral mass as well as section of posterior arch, both crowding into neural canal creating pressure-interference upon spinal cord.

Illustration No. 180.

Same specimen as 177. Compare 180 with 179. This picture adds axis, odontoid of which is seen fitting into fovea dentalis. Note absence of odontoid in 179. Because of distortion of atlas upon occiput, axis fits on angle thus distorting opposite relative positions of atlas and axis in occluding neural canal creating pressure-interference.

Illustration No. 181.

Spinograph taken thru skull, superior-inferior, showing relative outline position of atlas upon occiput. Same specimen as 177. Careful study of 179-180 shows, on R., slight tip of exostosis (small white spot) beginning to grow, eventually intending to ankylose odontoid process of axis. Axis not ankylosed in specimen.

Illustration No. 182.

Posterior view. Atlas and axis ankylosed to occiput. R. wedge-side-slip subluxation of atlas.

Illustration No. 182-A.

Same specimen as 182. Anterior view.

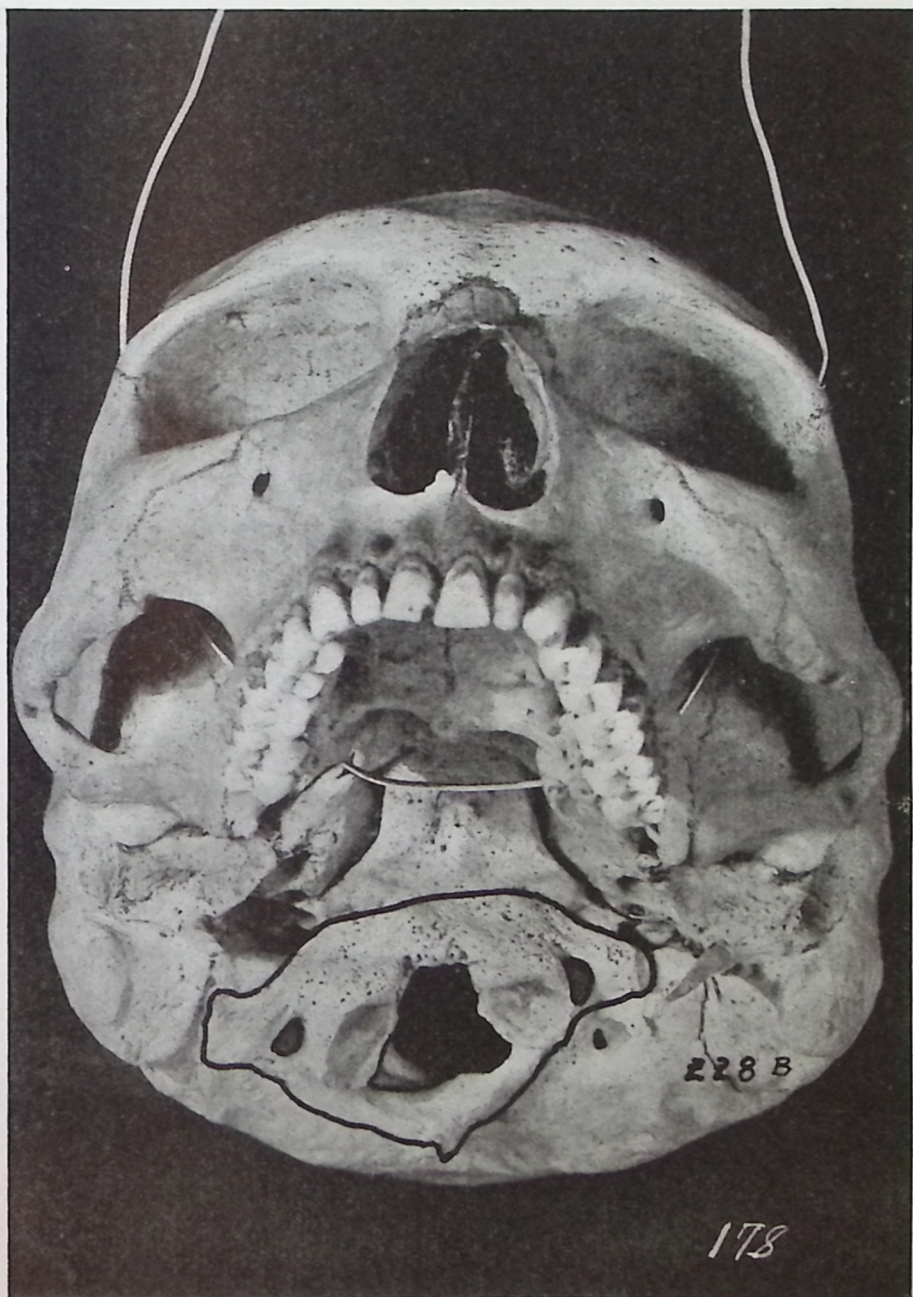


Illustration No. 178



Illustration No. 179

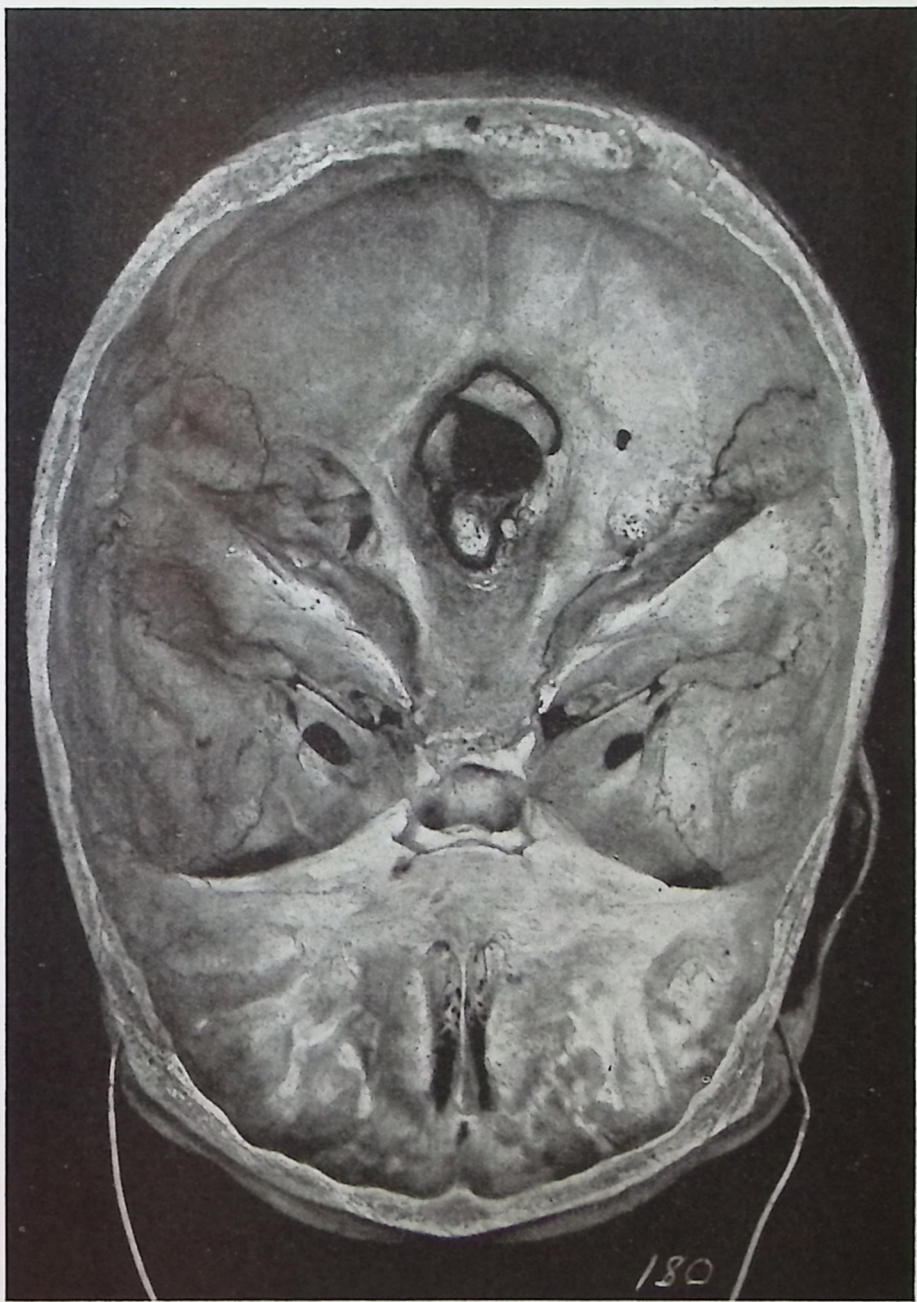


Illustration No. 180



Illustration No. 181



Illustration No. 182



Illustration No. 182-A

ADJUSTING



NEW information brings forth new interpretations upon old conditions, thereby giving greater understanding of improved service.

Is there a vertebral subluxation in a DEAD man?

Can an adjustment be given a DEAD man?

Is it possible to have fractures, dislocations, and misalignments in DEAD men?

Is it possible to push, shove, move, or crack vertebrae in DEAD men?

Is there a distinction between fractures, dislocations, misalignments in DEAD men, and vertebral subluxations in LIVE men?

Is there a distinction between pushing, shoving, moving, or cracking bones in DEAD men and ADJUSTING a vertebral **SUBLUXATION** in LIVE men?

Is it possible to **READ** a vertebral column with **NCM** in a DEAD man? If not, why not? If so, how?

Spinograph does not and cannot show **SUBLUXATIONS**. It proves **MISALIGNMENTS**.

I present two spinographs. Can you tell which is of **LIVE** man; which is of **DEAD** man; whether both were **ALIVE** or both were **DEAD**? Spinograph cannot reveal that difference.

Four elements **PROVE** vertebral subluxation:

1. misalignments in relation to ones above and below
2. occlusion to foramen
3. pressure upon nerves
4. interference to transmission of mental impulse supply.

Spinograph proves first two **DEAD** issues.

NCM proves last two **LIVE** issues.

Vertebral subluxation is **ONE** vertebra (not several) out of normal alignment with co-respondents above and below. A concussion of forces, where invasion was greater than resistance, **PROD**uced it. Vertebral adjustment is **ONE** vertebra (not several) restored to normal alignment with co-respondents above and below. A concussion of forces wherein resistance was lowered and invasion stepped up, **RED**uced it. **TWO** forces — invasion and resistance—must work in a **LIVE** person. For this

reason there can be NO subluxation in dead, only ONE force being present—invasion. For this reason there can be NO adjustment in dead, only ONE force being present—invasion.

Bones can be shoved, pushed, or cracked in dead. There is NO resistance. Introduce invasionary SPEED to LIVE man, and he resists with recoil speed, which speedy resistance adjusts the subluxation. Innate cannot recoil on slow movement induced by shove or push. She recoils only where there is necessity for a rebound. She will recoil on a quick delivery of forces approaching invasion, or following invasion. Adjustment with "that extra something with staying-put value" is the correction made by Innate on its recoil rebound to a speedy invasionary force.

There are four phases to a toggle, recoil, torque, Innate adjustment that produces that extra something with staying-put value:

1. APPROACH on part of Chiropractor, with invasionary force
2. DELIVERY on part of Chiropractor, with invasionary force
3. ABSORPTION on part of Innate of patient, with resistance force
4. RECOIL REACTION on part of Innate of patient, with resistance force.

There are three periods of time element:

1. Chiropractor relaxes (before adjustment) while patient usually contracts (before adjustment)
2. Chiropractor contracts (during adjustment) while patient should be relaxed (during adjustment)
3. Chiropractor relaxes (in get-away after adjustment) while Innate contracts (after adjustment)

They work in opposites. They synchronize in opposites to attain the adjustment with that extra something, with staying-put value.

Restating this:

1. Before adjustment, Chiropractor is relaxed; patient is contracted
2. During adjustment, Chiropractor is contracted; patient is relaxed

3. After adjustment, Chiropractor is relaxed; patient is contracted.

There is a maximum of contraction of Chiropractor at time of minimum of contraction of patient. There is a minimum of contraction of Chiropractor at time of maximum of contraction of patient. 75% of value of a toggle-recoil-torque-Innate adjustment is in what Chiropractor does when he does it; and what patient does not do when it shouldn't be done.

At first, the "adjustment" was crude, bungling, push, pull, or shove. We heard them crack and pop. We thot, so long as we felt them move, the patient felt them move, and we heard them crack and pop, a good ADJUSTMENT had been given. Every deviation being a "subluxation," we popped, cracked, and shoved them all. Why omit any? The more we shoved, the more the patient was getting for his money. The more shoves, the quicker he would get well. It was one of our pet phrases then: "If the 'adjustments' don't do any good, they can't do any harm."

One first and original desire was to align spinous processes so they were in alignment. I was one of those early unfortunates to be so experimented upon. The tips of my spinous processes are as straight as a plumb line, yet I have a double scoliosis as a direct result.

Spinograph eliminated much, confining ourselves to "adjusting" those which were "subluxations," which we thot we could see with the eye. But even the eye was not good enough to SEE a subluxation. It could SEE misalignments and deviations but it could not SEE a subluxation.

Majors and minors corrected much of what remained. We would ask questions, get history, secure symptomatology and pathology, deduct which set or group was most dangerous to present life of patient; again we deducted, trying to locate ITS subluxation, "adjust" that exclusive of all else. Every reduction in number of "subluxations" adjusted, stepped-up our percentage of results.

Then came the NCM with its evolution of technique, always stepping upward in interpretation of what we were getting by way of readings of comparative temperatures which indicated locations of nerve pressure mental impulse interferences.

NCM reads "heat." Heat has several sources of origin:

1st. Resistance to transmission of abstract energy flowing thru concrete substance. Energy behind keeps pushing energy forward. Obstruction prohibits getting thru, hence it works in excess at place of resistance. Work always produces heat. It is impossible to say that NO chemical reaction occurs, yet it is reasonably safe to call this "electrical energy resistance heat," in preference to its being chemical heat.

2nd. Mechanical frictional heat, created by work, wherein lubrication is absent between movable sections. This is possible and frequently happens in the human body, not only between osseous structures but between soft tissues.

3rd. Chemical, wherein elements oppose elements setting up excess work, more than needed by structures normally. That heat occurs in combustion, in a human body, is well known.

Which of these heats does the NCM read? At, in, and around spinal column, at place of interference, electrical resistance energy heat. If NCM was used to read heats of effects, at peripheries of nerves, in tissue structures dis-eased, the third or chemical heat. That it may be difficult or possibly impossible to segregate each of these, in a living human body, is obvious. That they can be set forth as abstract hypotheses, in a laboratory, is obvious.

Gradually this evolution has been gone thru, learning to ADJUST ONLY where there WERE interferences to transmission. At first, under placement technique, we found many places. Under gliding technique, we now find ONE place of interference, rarely two.

(See Illustration 140 with text which proves that unless accuracy of locating interference is used, you may not find this ONE most important place.)

Today, the less we do, if done right, the more results we get. We have learned that damage has been done in the past by "adjusting" places that were not SUBLUXATED; creating traumas, producing SUBLUXATIONS. The new phrase is true: "If adjustments don't do any good, they can do harm."

Enlarging upon above paragraph: if atlas wedge-side-slip is adjusted from abnormal L. HI to normal center position, that is all that can be done. If less than that is done, no good accrues.

If "adjusted" from L. HI beyond center, to R. HI or R. LO, damage has been done for it has been "over-adjusted." If an atlas L. HI has been adjusted to normal center, and chiropractor continues to push or shove it, or even recoils it beyond normal center, he then creates subluxation on opposite side and creates interference. Thus "adjustments" when not such in fact, CAN do harm.

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis," this Chapter.

With present day knowledge of atlas wedge-side-slip and neural canal pressures and interferences, axis subluxations with dangers of adjusting wrongly on "LO" subluxations of atlas, etc., retrace to days of "T.M." when we placed thumbs against transverse process of atlas and used head as a fulcrum and jerked head to side of thumb pressure; how we would lay patient back-down on table, stand at head, pull head away around, pulling it towards us and give it that violent quick little jerk that made all cervical vertebrae "crack". Recall the various and many devious ways we twisted and squirmed that neck—can you wonder how anybody got well, continued to live; how everybody wasn't damaged at our hands? Fortunately, in our ignorance and incompetence, we occasionally did the right thing, right way, at right time; a few got well, some didn't get worse; majority continued to suffer, exist and live in SPITE OF much we did wrong rather than BECAUSE OF little we did right. More wonderful than our clumsiness and incompetence is that dominantly powerful fighting personality of Innate Intelligence within that continues to struggle on, in opposition to what we do rather than any aid or help we made possible. Those days of misunderstanding and opposition to Innate are gone to chiropractors who are sincere in desiring to increase their efficiency.

If it were possible to take the same case and follow it thru with two different Chiropractors, here is what could and has actually occurred:

(a) He makes pre-check, "adjustment," and post-check for one certain day. Case returns next day; same reading appears. Another pre-check, same "adjustment" is given at same place in same direction; post-check shows that the major and several if not all minor readings are gone. This same action is repeated

day after day, READING REAPPEARING and same subluxation READJUSTED, DAY AFTER DAY — a condition which might occur for several weeks or months, with never a complete continued checking out of readings. This frequently brings forth the question: "When should we cease 'adjusting', assuming same readings consistently keep reappearing, day after day?" The answer now is: notwithstanding daily "adjustment" daily checks out readings, I doubt if there has been AN ADJUSTMENT given in that case.

(b) Another Chiropractor makes pre-check, gives ADJUSTMENT ("the adjustment with that extra something") and post-check shows readings are gone. The case appears next day and continues to reappear for many days, with no sign of a return of major, and perhaps several of all minor readings. It proves this IS an ADJUSTMENT ("the adjustment with that extra something") WHICH IS MAINTAINING ITS ADJUSTED POSITION FOR A LONG PERIOD OF DURATION—even unto a consistency for several days or weeks. ("The adjustment with that extra something").

In one instance we get an actual reduction of readings following ADJUSTMENT, but it returns sometime before next day arrives. Who knows just when? Maybe within the hour; maybe not for several hours — but the fact that it is present NEXT DAY, proves it did return WITHIN 24 HOURS, sometime. In the other instance, we get an actual reduction of readings following ADJUSTMENT, BUT IT DOES NOT RETURN WITHIN NEXT 24 HOURS, nor does it return within next few days, or several weeks, proving there are ADJUSTMENTS ("The adjustment with that extra something") and "adjustments" — some that return and some that stick.

If atlas wedge-side-slip, or axis odontoid interference into neural canal, is corrected by adjustment, then we arrive where there is NO interference and it stays put so long as that vertebra remains in normal position. If either were partially moved, they slip back to old abnormal position; and, while there is temporary releasure, it has no staying-put value.

I began to find that my ADJUSTMENTS were permitting readings to return daily; then gradually time between began to

lengthen. For a long time I found my average was one ADJUSTMENT every five days, over a gross number of cases. I found I could give an ADJUSTMENT ("the adjustment with that extra something") that lengthened itself to where my record case now is 10 months before another was necessary because of a return of SUBLUXATION. Still another case was ADJUSTED ("the adjustment with that extra something") only three times in six weeks, or an average of once every two weeks.

In analyzing difference, let me suggest there IS a real, genuine, and tangible difference. NCM does not lie on facts. Early return of readings indicates early return of SUBLUXATION, showing it was only PARTIALLY "adjusted", therefore did not remain permanently in situ. The prolonged check-out of readings indicates prolonged return of SUBLUXATION, showing it was more completely ADJUSTED ("the adjustment with that extra something"); therefore did remain more permanently situated. Has the hour arrived when we are on the eve of a discovery of supreme importance of making one ADJUSTMENT ("the adjustment with that extra something") a PERMANENT action, with PERMANENT restoration of position, with PERMANENT releasure of pressure and PERMANENT return of normal transmission, hastening materially the marvelous return to health of otherwise dying people?

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis," this Chapter.)

Cases will arise where, if there are multiple readings along the spine, including the major above as well as locals below, the ADJUSTMENT of the one above will GRADUALLY reduce one, leaving all others more or less in status quo—neither increasing nor decreasing them, and this condition can run for days. We might even finally get the major out, leaving all others in the picture. How long before we should "adjust" lower ones? I am convinced we are facing a definite working and practical practice principle, viz., inferior readings are more often the result of definite and exact pressures from above, therefore all inferior readings are effects of a cause superior to themselves; therefore, given time, they will check out. I have had cases where inferior readings hung steady for days or weeks, and then began to come down without any local attempt to realign local inferior mis-

alignments. In time cases got well of everything, without anything done other than ADJUSTING major above.

The majority of Chiropractors work with the concept that THEY are the all-important feature of "adjusting subluxations"; that it is what THEY do that replaces a SUBLUXATION; and with this thot, they proceed to PUSH vertebrae into the position THEY think they need be pushed into. "Adjusting", in their minds, means PUSHING BONES INTO ADJUSTED POSITIONS. I never have such a concept. ADJUSTING a vertebra ("the adjustment with that extra something") is what happens AFTER my hands have left the back; it is that REACTION that occurs when INNATE recoils in body of patient, which resets vertebra into normal position. My work is an enticement to get INNATE TO MAKE THE ADJUSTMENT ("the adjustment with that extra something"). Invariably when INNATE ADJUSTS SUBLUXATION it stays longer and readings remain absent longer and patient gets well quicker, and I can take more dangerous cases and get them well; where otherwise anything I did would have failed.

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis," this Chapter.)

If you asked me to classify "adjustments" in ratio to value to the sick, I would give five divisions:

1. KISS "adjustment" where Chiropractor comes down lightly, indents skin, deliberately draws hands away quickly, asks patient, "Did it move?"; repeats daily, prayerfully hoping his case gets well. Sooner or later, this man sets himself up as a standard on "limitations" of application of Chiropractic principle.

A "kiss adjustment" would be where adjuster lightly tapped skin, did not follow thru, used much force slowly; his technique being questionable in losing delivery by elbows not coming together, shoulder drop failed, etc. It was not an adjustment because forces not transferred did not move atlas lateral wedge-side-slip to normal center, nor did they move axis odontoid from abnormal pressure interference position back to normal relation with fovea dentalis to release same. As well tap a patient on the wrist as to tap him on the neck.

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis," this Chapter.)

2. TREATMENT "adjustment" where Chiropractor stuns "subluxations", many of which he finds, jars them into a paralyzation. He is a hit-and-run adjuster; feels highly delighted with his work; wonders why his NCM doesn't show a change, why his case doesn't show permanent improvement, and finds it necessary to keep case coming month after month. Sooner or later, this fellow's NCM goes on the shelf and he installs radionics, etc. He becomes a mixer because he found Chiropractic to be "limited" in practice.

A "treatment adjustment" is more than a "kiss adjustment" and less than an adjustment; delivers sufficient force to stimulate surface impulses; maybe relaxes a trifle; jars and stuns vertebra subluxated but does not follow thru. This "adjustment" does not re-locate a wedge-side-slip toward normal position; neither does it change an odontoid-pressure-interference in neural canal.

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis," this Chapter.)

3. SHOVE AND PUSH "adjustment" where we want to feel something "move," hear something "crack," think WE know where IT ought to be put, and proceed to put it there. This Chiropractor wonders why his case gets better, gets worse, and might get well by accident; but leaves him up in the air as to what happened. He knows Chiropractic is right because it occasionally works.

A "shove and push adjustment" is delivered with heavy thrust, slowly. It usually is given stiff arm, shoulder weight drop and when at the bottom of the thrust is held pushed down. A daily series of slow shoves or pushes directs atlas wedge-side-slip alternately from one side to opposite, constantly shifting neural canal pressures. Or, if shove or push is "hard" enough it might direct atlas-wedge-side-slip from side of abnormal position to opposite side in ONE movement. Axis can be shoved or pushed to increase odontoid more into neural canal posterior. By far most dangerous to use.

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis," this Chapter.)

4. AN ADJUSTMENT-ADJUSTMENT where we deliver a

light, quick recoil concussion of force, letting Innate absorb and recoil in retaliation; knowing Innate will ADJUST to correct normal position where it belongs and will best stay for longest possible time. This Chiropractor works at location and position and with delivery by intention; checks and secures what he, as well as patient, wants because all is done in cooperation WITH Innate rather than in opposition TO Innate. This Chiropractor is constantly and severely checking HIMSELF.

An "adjustment-adjustment" would be just that if, once correctly done, is left alone. It ceases to be that at any time if chiropractor keeps fooling with good work well done and refuses to leave well enough alone.

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis," this Chapter.)

5. Then there is that "ADJUSTMENT WITH THAT EXTRA SOMETHING" which has become a habit. He has arrived, attained, works deliberately, and knows how to secure that which he wants, day after day, on case after case and can and does duplicate like results repeatedly. This man couldn't be side-tracked from Chiropractic if you gave him the medical armamentarium.

When all elements are correct and chiropractor knows when to and when not to, and does not try to improve upon a vertebra that IS in normal position, then it is "staying-put-value."

There are "adjusters" AND adjusters; most of whom THINK they do, but most of whom DON'T. There are "adjusters" who kiss the back; there are "adjusters" who shove and push bones from where they were to where they think they should go; and there are Chiropractic ADJUSTERS who have conceived that THEY don't give an adjustment; that Innate alone, in body of patient, can recoil or snap the vertebra into normal position. That's why you can't give an adjustment to a DEAD man. It takes LIFE in the sick man to make it possible. It has been said so often here that it is a standing joke, that I possess "uncanny skill" in locating interferences and getting MY sick well. MY sick are no different than YOUR sick; MY NCM no different than YOUR NCM; my technique no different than yours—but there is ONE thing I do IN THE WAY I DO IT, that

is different than 99% of Chiropractors and that is my ADJUSTMENT ("the adjustment with that extra something"). I GET an ADJUSTMENT ("the adjustment with that extra something")! If YOU will do EXACTLY what I do, EXACTLY as I do it, you can attain EXACTLY the same results as I do. The greatest failure in our ranks is inability of majority to give an ADJUSTMENT ("the adjustment with that extra something"). If ALL Chiropractors could give AN ADJUSTMENT, there would be less alibiing, substituting adjuncts, advertising how "limited" it is; more results would be delivered, and Chiropractic would be a deliberate, tangible asset.

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis," this Chapter.)

If the Chiropractor will work to secure an INNATE ADJUSTMENT ("the adjustment with that extra something"), utilizing his forces merely as a means to an entrée to get Innate to make the ADJUSTMENT, he will find that the SUBLUXATION will stay ADJUSTED more permanently than before.

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis," this Chapter.)

There is a difference between the Chiropractor who pushes the vertebra into place he thinks it should go, and the invitation to Innate to put the vertebrae where SHE knows they belong, when she can recoil or snap them into place.

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis," this Chapter.)

Let us present three premises:

1. Your NCM readings are inaccurate
2. Your SPGH listings are correct
3. Your adjustments are delivered perfectly.

What follows? No results!

Why? Locations and times of interferences were WRONG.

1. Your NCM readings are accurate
2. Your SPGH listings are incorrect
3. Your adjustments are delivered perfectly.

What follows? No results!

Why? Position of vertebral subluxation was WRONG.

1. Your NCM readings are accurate.
2. Your SPGH listings are correct
3. Your adjustments are delivered imperfectly.

What follows? No results!

Why? "Adjustment" was not such in fact.

IF NCM readings ARE accurate

SPGH listings ARE correct

ADJUSTMENT is such, results WILL follow.

Innate is a FIXED quantity, ALWAYS present.

(See "Science Duplicates Itself," Chapter V.)

I hear comments about "giving a LIGHT adjustment for psychological effect"; or "I gave him a HARD adjustment because he can stand hard ones." There is no such thing as a "light" or "hard" adjustment. There is or there is not a necessity for AN ADJUSTMENT ("the adjustment with that extra something"). If there is, give AN ADJUSTMENT ("the adjustment with that extra something"); if there is not, do not give any. Any work, when none is needed, is unnecessary; and anything unnecessary is dangerous, if tried. AN ADJUSTMENT is that which Innate will ADJUST itself to. If it needs a violent jar to recoil the vertebra into alignment, then Innate will give it. If it needs a "light" readjustment, Innate will perform it. These are questions Innate of patient can judge.

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis, this Chapter.)

WE are prone to think OURSELVES mighty all-fired important, without which nothing can be done. WE think WE are the pumpkins and the IT of all health business. So WE say: "I cured her. It was MY treatments that got her well." Do we not all underestimate the value of Innate, and overstress the importance of OURSELVES in doing anything?

At a recent convention, we held a Chiropractic NCM clinic. A case was pre-checked; a Chiropractor "adjusted", and did not reduce the readings. I ADJUSTED ("the adjustment with that extra something") the case, and all checked out. The question was then asked: "Would you call that an ADJUSTMENT?" My answer was: "I do not know. It might take several days to find out"—meaning, of course, that time would prove whether the vertebra remained in proper position or not; and only time could prove that point.

The great and ultimate objective in all our work, study, concentration, application, palpation, graduation—is that when THE

ADJUSTMENT is given, the SUBLUXATION remains in the normal position that Innate recoils it into. Any detail that helps to attain that end is not a detail, it is a vital issue and cannot afford to be overlooked as a matter of office procedure, no matter what it costs; how much it inconveniences, or what trouble it creates for you.

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis," this Chapter.)

A patient enters; you give pre-check; find a high enough reading on major to warrant giving an ADJUSTMENT. Having given ADJUSTMENT, you post-check; find the occlusion has been opened, pressure released, transmission restored—what is the next OBVIOUS thing to do? TO HELP IT STAY THERE AS LONG AS POSSIBLE. If it can be HELPED to stay in situ for six weeks, case will get well quicker than if it were NOT HELPED to stay there six hours. Is there, then, any one detail which YOU AND THE PATIENT CAN DO, which will HELP it stay in normal position? Obviously! HAVE PATIENT LIE DOWN for a period following ADJUSTMENT. How long, may be a question. I have my cases rest a half hour, flat on their backs, on a simple, plain couch.

I know the futile arguments against resting — the patient hasn't time, or won't take it; can't afford to rent the room for that purpose alone, or you don't see the necessity for resting, etc. You CANNOT AFFORD TO NOT do those things which help attain that one essence of focalized and concentrated objective—SUBLUXATION remaining ADJUSTED.

My cases come day after day. If the readings are clear, they do not rest. IF a reading appears and an ADJUSTMENT ("the adjustment with that extra something") IS given, they MUST rest, willy-nilly. No excuse can be offered by the case which permits me to withdraw that necessity; neither will I permit myself to think any other condition vital enough to withdraw the rule from my office procedure. EVERY CASE THAT RECEIVES AN ADJUSTMENT ("the adjustment with that extra something") MUST REST!

The adjustment for ANY AND ALL torqued subluxations will be with nail point ONE upon either transverse process of atlas OR axis spinous process. Great emphasis is now being

laid to see that it IS nail point one, of nail hand, that is used. Many Chiropractors are careless and get some other place laid down. We find, in checking thousands of Chiropractors, in palpating out the spinous process of axis, they usually find IT, but when it comes to placing their nail point ONE on spinous process, it is usually their nail point TWO that lands on the LAMINA of axis; thus losing highest efficient contact for untorquing a torqued subluxation.

(Illustrations 126 to 131 have been taken especially to emphasize this particular phase of our work. Study its detail carefully.)

Also, checking Chiropractors in their adjusting work, we find they usually place nail point TWO on lamina of atlas somewhere between transverse process and posterior tubercle of posterior arch of atlas. I KNOW OF NO MORE PARTICULAR DETAIL TO EFFICIENT, CORRECT, ACCURATE, AND HONEST WORK THAN CAN BE PORTRAYED RIGHT HERE IN THIS QUESTION OF CONTACT. Transverse process of atlas lies anywhere from a plane line with the inferior border of mastoid process to within one-half inch or more below that point. It forms a V-shaped crotch. In properly building up nail hand, we form IT into a V-shaped arch, thus permitting nail point ONE, at POINT of that V-shaped-arched-hand to fit into V-shaped portion of jaw and skull. With this leverage, direction being right, delivery natural, any torqued atlas can be EASILY adjusted. If mistake is made of getting nail point two on lamina of atlas, good might be done; harm could be done; and great damage has been frequently reported. In adjusting axis, the average Chiropractor lays his hand more level or flat on neck, thinking he is on spinous process. His hand should be around on the roll or cutting edge more to get nail point one on spinous. If, by mistake, he gets his nail point on lamina, thinking he is on spinous and gives on adjustment ON LAMINA intended, in quantity of direction for spinous, it needs no imagination to realize what is going to happen to the misplacement of odontoid process out of its fossa worse than it was.

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis," this Chapter.)

The ultimate objective of EVERY adjustment MUST be to increase size, shape, diameter and circumference of all occlusions,

to release all pressures, to correct all interferences and to restore all transmissions whether that be between occiput and atlas, atlas and axis or to replace odontoid process of axis into normal situ, to give freedom to passage of spinal cord without pressure, to permit a normal free full 100% quantity flow of mental impulse supply between brain and body; to release brain congestion above and release body starvation below.

(While thinking on this question, hastily glance over lateral spinographic case photos, either in this book or in your view-boxes, and study necessity for correcting position of odontoid processes.)

Two GENERAL directions are obviously necessary, in all adjusting work: (1) to adjust atlas from an anterior subluxated position to a posterior: (2) to adjust axis from a posterior subluxated position to an anterior. With these two GENERAL directions must be added a correct visualization of THE ADDITIONAL combination directions which are individualistic to each torqued subluxation to each person, as no two torqued subluxations are ever alike in any two people; always varying in degrees.

When head, atlas, and axis are subluxated low on one side or other, the adjustment obviously raises opposite side. If atlas is a wedge-side-slip to right or left, high or low, plus being anterior AND SUPERIOR or anterior AND INFERIOR, then it must be adjusted from that side according to which it is wedged. This means that great care must be used, by Chiropractor, in seeing that his adjustment IS OF THAT CHARACTER AND IS SO DELIVERED THAT IT ACCOMPLISHES THE DIRECTIONS NECESSARY TO CORRECT THE TORQUED SUBLUXATION. We cannot here emphasize too strongly that too many "adjustments" are far short of being just that; that many of them are nothing more or less than punches somewhere in a back, given in some way without regard to perfect re-alignment of perfect correction to accomplish the objective vitally necessary to unwedge the atlas or replace the odontoid back into its fovea dentalis articulation, in perfect apposition.

(See enlarged study of this subject, under heading, "Adjusting Technique of Torqued Subluxations of Atlas and Axis," this Chapter.)

RULES TO UNDERSTAND UNTORQUEING TORQUED SUBLUXATIONS OF ATLAS AND AXIS

With a PLI axis, true or false, stand on LEFT side of case.

Standing on LEFT side of case, LEFT hand is nail hand.

Even tho torqued axis IS left, torque LEFT elbow TOWARDS you.

With a PRI axis, true or false, stand on RIGHT side of case.

Standing on RIGHT side of case, RIGHT hand is nail hand.

Even tho torqued axis IS right, torque RIGHT elbow TOWARDS you.

With INFERIOR axis subluxations (and all axis subluxations ARE inferior) adjustment is to opposite, with nail-hand-elbow torqueing TOWARDS you.

With atlas torqued anterior and SUPERIOR, left or right, nail hand ALWAYS torques to INFERIOR, or towards you.

With atlas torqued anterior and INFERIOR, left or right, nail hand ALWAYS torques to SUPERIOR, or away from you.

One question which IS vital is to be able to decide accurately WHICH (atlas OR axis) to adjust. I know of no better way of answering that than to ask the reader to carefully study the level or plane lines as marked on the illustrations and let each speak for itself.

One or the other is the "key" vertebra to every angle of the torque that involves the position of the occiput, atlas and axis, in a direct combination torque; as well as all the misalignments inferior to it in the balance of the spinal column. If atlas is adjudged to be the torqued vertebra, DON'T adjust axis. If axis is THE offending vertebra, DON'T adjust atlas. ONE will unlock ALL if determined and adjusted correctly.

In every torque, the position of the head will be involved, either to left or right, forward or backward, in combinations. A lateral view will show whether head is leaning forward or backward. An A-P will show whether it is to left or right. Sometimes, and frequently, you will get a combination of back over either shoulder, showing both directions, etc.

ADJUSTING TECHNIQUE OF TORQUED SUBLUXATIONS OF ATLAS OR AXIS

After an extended investigation of many years; research of many kinds into many systems, methods, modes, and moves; observation and reports involving many thousands of cases, we have come to the following definite conclusions based on the exclusive process of deduction of facts:

1. The toggle-recoil method of adjustment is the only adjusting technique that possesses the potential possibilities, within the elements of which it consists, to correct and attain the highest degree of efficiency to put into practice the principle of untorquing torqued subluxations.

2. The knee-chest posture for adjustment is the only adjusting position that contains within itself the potential possibilities that make most active those relaxed states of muscles necessary to gain greatest relaxation to permit the invasion of that characteristic avenue of approach which makes possible the untorquing of torqued subluxations.

3. To untorque a torqued subluxation with that "extra something" with "staying put" value, means to correctly replace the vertebra from its abnormal position to its normal position, in the quickest possible time, with the greatest permanency possible, with the least possibility of its return. To competently accomplish this objective means a complete reversal from mal-positioned mis-alignment to normal location; nothing short of a complete return being incorporated as a satisfactory objective.

4. The proper development of mind, muscle, and movement of the Chiropractor being something more than a placing of hands anywhere, any way, and shoving any bone or bones any direction in any gross manner, without regard for the finest details of an accomplished development of mind, training of muscle with an artistic movement. The time has arrived when untorquing torqued subluxations is an art that demands intensive thinking, training, and development of approach and delivery; absorption and adoption upon the part of the Chiropractor and the Innate of the patient.

5. The proper place to put the nail point of the nail hand is on the transverse process of the atlas or the spinous process

of the axis; remembering that while it is easy to say it should be there, that many seek to and think they have placed it there, yet few ever do place it where it belongs.

To assist Chiropractors to UNDERSTAND EXACTLY what is meant, we illustrate this particular detail of our work with a set of views.

(Again check over illustrations 126 to 131 to vividly impress this fact mentally.)

We have placed a skeleton on an adjusting table as nearly accurate as it was possible to place a skeleton that was wired stiff and is not flexible or adaptable to being properly positioned. In spite of the handicaps, it shows clearly and exactly where the transverse process is in relation to the mastoid process on its posterior and the ascending ramus of the mandible on the anterior. Transverse process of atlas lies anywhere from a plane in line with the inferior border of mastoid process to within one-half inch or more below that point. This view also shows the axis spinous process lying around to the rear.

(See Illustrations 126 and 131. The purpose of such views is to typify the actual case, lying on table, minus flesh, to give a picture of location of objectives for adjustment.)

This shows the position of the ARCHED nail hand with nail point resting squarely in and on the transverse process of the atlas. To get nail point NUMBER ONE in and on this transverse process it IS necessary TO ARCH THE HAND and thus make a V-shaped arch of the nail hand so that NAIL POINT NUMBER ONE could get in and on THE TIP of the transverse process of atlas.

(See Illustrations 128, 129, 130, and 131. This idea portrayed is VERY important. Study and practice it well.)

This view shows the position of the ARCHED nail hand with nail point NUMBER ONE resting squarely in, on and under the spinous process of axis. To get nail point NUMBER ONE in, on and under this spinous process of axis it IS necessary TO ARCH THE HAND and thus make a V-shaped arch of nail hand so that NAIL POINT NUMBER ONE could get in, on and under tip of spinous process of axis.

The tip of this atlas transverse process is oval, therefore has no corners; but if it could be said to have corners, those become.

important as places where nail point one is placed for various directions of adjustment. If atlas be anterior and superior, then you get as much up on the AS corner as possible. Obviously, you wouldn't get back on posterior corner of a superior subluxation to adjust it to posterior. Same is equally true of axis. It has a larger spinous process, is usually bifurcated, and has longer prongs. Obviously, if you have a PLI subluxation, you wouldn't get on or over lower tip of right prong to adjust it to right and superior. And, in all torqued axis subluxations, where "I" is a cardinal question, be SURE you properly place nail point number one UNDER axis spinous process that leverage may be obtained in RAISING axis superior and anterior to throw odontoid process back into its fossa. Many a Chiropractor thinks he is UNDER axis spinous process when in reality he is somewhere on TOP of it, thus directing the force of his adjustment to the INFERIOR and making torqued subluxation worse by directing odontoid process OUT of its fossa more than it was.

IN BOTH INSTANCES THE NAIL HAND MUST BE UP ON CUTTING EDGE. The nail hand cannot carelessly lie flat on neck; neither can nail point number two be used; neither can nail point number one or nail point number two be placed so as to lie in, on, or SOMEWHERE AROUND transverse process of atlas; or in, on, or SOMEWHERE AROUND spinous process of axis; or in, on, or SOMEWHERE AROUND lamina of atlas or lamina of axis. The day of "somewhere in, on, or around" is gone if one finds it necessary to untorque a torqued subluxation.

(In illustrations between 126 and 136, note how nail hand is ALWAYS kept arched. This arch is NEVER broken down, even when actual adjustic movement is given. Many Chiropractors DO break it down by flattening it out, when they attempt to give adjustment.)

Many Chiropractors so place their nail hand that THEY THINK they are in, on, or around the transverse process of atlas or spinous process of axis; but both are on lamina. I know many Chiropractors WHO THINK they place their hands so they get a direct cutting edge of their directly released forces upon ONE vertebra when in reality forces they transfer from their hands into spinal column spread over SEVERAL

vertebrae and thus do more harm than good — and wonder why they fail to get sick people well. I know many Chiropractors who lay their nail hand so flat on the neck that their nail point hits an atlas or axis somewhere above and the ball of the hand under the thumb is so flat on the back that it hits the spinous process of sixth or seventh cervical vertebrae, or both, and thus separates the atlas or axis SUPERIORLY away from the sixth or seventh cervical vertebrae INFERIORLY and neither gets an "adjustment" and the torqued subluxation is ignored so far as untorquing it is concerned.

Note views of HOW nail point NUMBER ONE of nail hand can and does rest in and on transverse process of atlas of a normal human neck, as well as in, on and under spinous process of axis. It CAN be done but he must KNOW exactly WHAT he is doing, WHERE he is doing it, and HOW it is to be done before doing any of it.

(Check views 128 to 131 showing HOW to correctly place nail point one to attain highest efficiency.)

He who studies spinographs with objective of correcting damage done, understands the necessity of adjusting odontoid process from its abnormal position in neural canal back to its normal position in fovea dentalis. With this understanding, to accomplish that objective, it IS necessary that he adjust on a certain place on transverse process of atlas to reverse its position; or, a certain place UNDER spinous process of axis. He then proceeds to do that certain thing with the exception that HE DOESN'T DO IT. He thinks he does. What happens is that by the time he has his nail point "correctly" placed, it is ON LAMINA of atlas or on LAMINA of axis. With an atlas and axis in hand, see what adjusting ON LAMINA of axis will do to odontoid—directs atlas AWAY FROM it. With an atlas and axis in hand, see what adjusting on lamina of axis will do to odontoid—directs axis away from atlas. In both instances "adjusting" odontoid abnormally throws it more back into neural canal and INCREASING pressure with DECREASING transmission. Utmost care MUST be used to CORRECTLY place nail point; direction of delivery of adjustic movement is equally as important to reverse the condition causing the correction.

Adjusting an atlas wedge-side-slip is a "delicate operation", if

I might use a surgical term. If it were not for Innate Intelligence, it would be a "dangerous operation." Innate and Chiropractor COOPERATING, it is an easy chore with marvelous results possible.

There exists no lock laterally to prevent atlas side-slipping, as result of accident, other than cupping effect of superior articulations with condyles which obviously has not prevented violence from side-slipping them. I know no reason why, in absence of a non-existing lock, to prevent atlas being side-slipped as result of "intention" upon part of Chiropractor who intends to give adjustment but creates an "accident."

Assume a R.HI atlas wedge-side-slip. This calls for ADJUSTMENT of atlas to reestablish relationship with occiput above and axis below; to bring atlas back to a median line when it is exactly below occiput and exactly above axis and equi-distant laterally in that relation above and below. This means to relocate atlas superior articulations in APPOSITION with condyles above and APPOSITION with inferior articulations with axis below. If this IS DONE, we release pressure of left atlas bony ring upon spinal cord between magnum foramen and atlas. IF atlas IS corrected to accomplish THAT correction of position AND RELEASE of pressure, patient WILL get well, other things being equal. Suppose Chiropractor corrects R.HI wedge-side-slip, adjusting it to left and "follows thru" (which he should do); but in "following thru" SHOVES IT THRU TO LEFT and makes a LEFT HI or LO. He will have reversed direction of subluxation; caused pressure of right atlas bony ring upon spinal cord between magnum foramen and atlas. The adjustment that RESTORES health moves in distance from subluxation to apposition. The "adjustment" that DESTROYS health moves in distance, from subluxation to adjustment thru to subluxation on opposite side. The adjustment went beyond adjustable necessary distance and then became a subluxation to extent beyond its normal position into which it was shoved. It could be a subluxation-adjustment from R.HI to median line; when it went BEYOND that median line, to left, it became a LEFT subluxation.

So, an adjustment CAN become a subluxation by increasing adjustment direction beyond its natural normal position. Pa-

tient will note let-up of OLD chronic symptoms, because of release of those pressures, but he will note creation of NEW acute symptoms. Retracing? Far from it! A case in point: In a recent clinic, a D.C. brot a chronic case for our NEW work. After first class in instruction on NEW work, he read films and adjusted according to OLD method of adjustment, which was a slow shove. He innocently side-slipped atlas from ONE side TO other. Within a few hours case had temperature of 104°, was almost "out of his head." An experienced adjuster in our NEW work, from our staff, was called. He adjusted case SAME DIRECTION as other Chiropractor, using FAST RECOIL, and case came quickly out of tail-spin. Spinographs in both instances were read correctly, which agreed.

If an atlas CAN BE wedge-side-slipped TO right high; and IF it IS torqued, wrenched, locked in three directions on that side; and IF it CAN BE unlocked, untorqued by an adjustment FROM right high wedge-side-slip TO normal or central position BETWEEN occiput and axis, then we MUST BE CERTAIN that it IS unslipped, and careful that it is NOT wedge-side-slipped TO the other or left side. An adjustment consists of JUST SO MUCH and not any more; but it MUST BE that "just so much." If there are no locks to prevent atlas wedge-side-slipping TO right, and no locks to prevent its being adjusted TO median line, then it is certain that there are no locks ON OTHER SIDE to prevent its being OVER-adjusted TO left.

Atlas, to be normal, must ride all articulations in normal center, neither left nor right of that dead center. If atlas rides dead center there will be no pressure-interference at inter-magnum-atlas foramen. Axis, to be normal, must ride its odontoid in normal relation with fovea dentalis; neither posterior, left nor right. If axis rides dead center there will be no pressure-interference in neural canal.

Let me illustrate a procedure:

MONDAY. 3 pt. R. NCM reading. Spinographs reveal L. HI, ASL atlas wedge-side-slip subluxation. Adjustment given on L. transverse. NCM readings clear. Pressure gone. L. HI is now dead center in correction of position.

TUESDAY. No NCM reading. Nothing to be done. Nothing

can be done. All desired has been attained. Anything done, NOW, would be wrong.

WEDNESDAY. Case complains of "being stirred up, feeling bad, suffering. Surely you will find a reading today. Something MUST BE done or I will see another doctor." NCM check shows NO READING. Mental impulses ARE getting thru. Whatever feelings the patient has are adaptative conditions changing. Innate is rebuilding, correcting, restoring. If YOU are weak, here is where YOU weaken. You "do something" to ease patient's mind. You "adjust" atlas from L. HI because THAT is major, even tho there WAS NO reading.

THURSDAY. Case complains of drawing on side of neck, full head, temperature, dullness, groggy, sluggish. You check and note a 2, 3, 4, or 5 pt. L. NCM reading. Opposite to where it was Monday. Why? What happened?

You side-slipped L. HI atlas into R. HI or R. LO Or, if it was axis you adjusted on superior of spinous or on its tip, thinking to take it out of neural canal, when you actually carelessly drove it posterior and inferior INTO neural canal more than before.

On Wednesday when you couldn't keep your hands off of good work well done, didn't know when to let better judgment dictate your actions; when you let sympathy and symptoms prejudice (pre-judge) your observed conviction, was when you took atlas from "dead center" and subluxated it to R. Or, you over-played position of axis, was careless and made IT worse.

Many a case has been "adjusted" from a L. to a R. atlas wedge-side-slip subluxation. Or, axis odontoid has been driven more into neural canal. It is well to know WHEN to stop. This explains frequency of reversed readings, in superior cervical region, from day to day. To every chiropractor who UNDERadjusts an atlas side-slip and does not adjust it FAR ENOUGH; or, who OVERadjusts an atlas side-slip from one side TO other; or, who is careless about adjusting odontoid into relation with fovea dentalis, the HIO as a principle, practice or system would be a myth and a failure. To him, punching bones below axis that crack and pop would be a safer procedure and method.

HOW can WE KNOW when atlas or axis is normal? Is palpation a sufficient guide? Is X-ray, before and after, the method to use? Is patient, his feelings put into words, or his described

symptoms, reliable? Is there any more positive or safe guide than NCM with its absence of pressure-interference?

(See previous study, this Chapter, under heading, "Adjusting.")

Chiropractors watching interference record of cases thruout entire spine, note fluctuations of degrees and changing locations of readings from time to time. They wonder! Side-slipping of atlas from one side to other could easily keep a Chiropractor guessing, especially if adjustment was not that in fact, which kept side-slipping atlas from one side to other, then reversing, especially if he thot he ought to over-adjust frequently and on every $\frac{1}{2}$ -point reading found in superior cervical region. This accounts for why some HIO workers, thinking they are adjusting correctly, at right times, report their cases get worse and make rash statements that "there is nothing to HIO because I tried it and got my cases worse."

Can adjustments be analyzed to know WHICH KIND is prone to permit it to reach normal situ and remain? Is there an art that can be developed which tends to establish CORRECT relationship in articulations and release pressures? After studying adjustments as applied by our profession, and checking many Chiropractors both in school and in field, I am convinced that a slow, stiff-arm, shove, heavy, direct-down, pressure movement upon atlas "drives" it thru from one side to other. If adjustment upon an atlas wedge-side-slip is given in a speedy recoil manner, it MAY actually spring BEYOND normal median line, but Innate RECOILING will snap it back INTO median line. If, however, an "adjustment" is given upon an atlas wedge-side-slip in a slow, shove, push manner, it CAN be made to go BEYOND normal median line, but Innate NOT RECOILING, it will NOT snap back into median line and stays BEYOND, where it should not have been shoved or pushed.

How much force is necessary to give an adjustment UPON ATLAS OR AXIS direct? How much force is necessary to make possible an adjustment upon atlas or axis when force is delivered AT SOME POINT REMOTE from it, in lower cervical, dorsal, or lumbar region? Is it a great deal, slight, or sometimes much and sometimes little? Must the quantity of force used increase in inverse ratio the farther it is removed from its correct location? Many factors enter into each equation which determine.

PROduction or REduction of subluxation is a question of comparative values of oppositional concussion of forces when they meet—whether invasionary force is greater than resistance or vice versa. The question OF QUANTITY of either or both does not seem to be such an important factor, as is how nearly they may be over or under-balanced to each other at moment they oppose each other. If human body was COMPLETELY relaxed, it would require less invasion force to PROduce or REDuce subluxation than if patient's body was at its maximum period of contraction at time of invasion. Putting it another way: if muscles in patient's body were tense, rigid, contracted, it would take a greater external Chiropractor's invasionary force to overcome that condition and PROduce or REDuce subluxation than if body was at NORMAL contraction.

If adjustment was attempted on atlas direct and body of patient was contracted, invasionary force would need be stepped up to overcome it. If adjustment was attempted on atlas direct and body of patient was relaxed, invasionary force would need be less to overcome it. If "adjustment" was attempted on 3rd lumbar and it was necessary to correct atlas to get case well, and entire body was contracted, it would take considerable force to be delivered at inferior lumbar to finally accomplish its needed objective at superior atlas. If "adjustment" was attempted on inferior 3rd lumbar and it was necessary to correct superior atlas to get case well, and entire body was relaxed, it would take little force to be delivered at lumbar to finally accomplish its needed objective at atlas.

For this reason, sometimes the slightest external quantity of invasionary force can and does PROduce or REDUCE subluxations. For same reason, sometimes an excessive external quantity of invasionary force seems necessary to PROduce or REDuce subluxations. Some Chiropractors give so-called "light" adjustments, regardless of whether it be an atlas direct or by remote control, and reduce readings and get sick people well. Others need "hard" adjustments and sometimes succeed, but more generally fail.

The reason the average Chiropractor thinks of giving adjustments in terms of WORK upon HIS part is because he usually does those things which induce patient TO RESIST invasion,

forces patient to contract muscles, and then when case is all hunched and bucked up against invasion, he tries to come thru, and finds he has a task under his hands. Being over-confident that what HE HAS DONE is 100 per cent perfect, he never finds the error of his ways. If average Chiropractor would think of an adjustment in terms of doing those things which cause his patient TO COMPLETELY RELAX, let go, he would find that giving adjustment "with that extra something with staying put value" was easy to deliver because there was little, if any, resistance upon part of patient, therefore took little invasion upon his part. There is still another MORE important reason. Subluxations are PROduced when muscles are caught unprepared (relaxed) for an emergency necessity. Same accident happening to same muscles, contracted, would not PROduce a subluxation. Subluxations are REDuced when same muscles are caught unprepared (relaxed) and taken advantage of by an invasionary force necessity delivered by a chiropractor. Same adjustment happening to same muscles, contracted, would not REDuce a subluxation. The Chiropractor has learned that HE CANNOT CONTRACT unless he STARTS from an absolutely relaxed condition. Same is true upon part of Innate IN PATIENT. Unless PATIENT is relaxed, Innate CANNOT CONTRACT. It is WHEN INNATE CONTRACTS in recoil that THE adjustment takes place that is vital that accomplishes its objective. As patient's resistance steps up, invasion must. As resistance relaxes, invasion can. An adjustment should be given as easily as possible, regardless of whether it be direct upon atlas or axis, or remotely upon other vertebra below. The average Chiropractor MAKES WORK of adjusting and wonders why it happens only occasionally. The ratio of "cures" depends upon the exercise of this principle which few Chiropractors seem to give serious study to.

I have said the Chiropractor "usually does those things which induce patient to resist invasion." In terms of technique what is meant? When in position, ready to give an adjustment, he will wiggle-waggle his elbows; raise hands up slightly and press them down again; or he will raise hammer-hand off nail-hand and place it down again, perhaps several times; in fact, ANY movement which releases hands-pressure on back and increases

it in alternate pressure. All this the patient feels. Feeling it, he knows you are going to strike, and therefore braces to be prepared. If Chiropractor attempts adjustment while patient is braced, Chiropractor must drive thru that brace, and that is what makes WORK of it and reduces percentage of cases getting well. In terms of technique, here is another serious fault. Many Chiropractors drag time period between when they step up to patient and give adjustment. Maybe several minutes will elapse. This is especially true with novices. They do so to think thru all the necessary correct detail. Meanwhile, case has plenty of time to think about what is coming and thus delay defeats accomplished desire.

The Chiropractor must so say the thing which will get patient's mind off his contracted back muscles and place it somewhere where contraction is of no consequence; i. e.: ask patient to spread feet apart; this causes muscles of legs to contract and in so doing muscles of back relax. It is at MOMENT this occurs that the contracted adjustment invasionary force should be applied to subluxated vertebra.

I have frequently said that 75 per cent of value of adjustment which patient pays Chiropractor for is something patient alone gives to himself, viz., relaxation. 75 per cent of value of adjustment, which patient came to Chiropractor to receive, is what patient gives to himself, viz., relaxation. And the odd part of it all is, Chiropractor, in 75 per cent of cases, unthinkingly or unwittingly WORKS to prevent any or all of this taking place.

For years, many in our profession have been thinking in terms of "hard" and "light" adjustments. WE MUST TRAIN OURSELVES TO THINK IN TERMS OF "FAST" OR "SLOW." Adjustments are just such and only INNATE makes them. "Accidents" that CAUSE subluxations, whether accident in fact or by "intention" of well-meaning Chiropractor, are sudden, violent, a concussion of forces with rapid delivery wherein external invasion overcomes internal resistance. "Accidents," called to my attention for correction (and they have been not a few) are created by Chiropractors whose "adjustment" when studied and analyzed, has been found to be slow, stiff-arm, shove, direct-down pressure type. On reverse, every Chiropractor who reports "miracle" HIO cases, which get well rapidly and are con-

sistent thruout his practice, has been an adjuster who has drilled and trained himself to increase and use a snappy, speedy recoil, wherein INNATE INTELLIGENCE ABSORBS SPEED AND RECOIL BY SNAPPING VERTEBRA BACK INTO NORMAL POSITION.

Mass x velocity gives quantity of force.

2 lb. iron ball x 10 feet per second equals 20 lbs. force.

1 lb. iron ball x 20 feet per second equals 20 lbs. force.

Mass in motion.

Place an automobile head on against telegraph pole Start engine. You do not move pole. Back car 50 feet. Full speed of engine, drive into telegraph pole and you snap it off.

The reverse is: decrease mass and increase velocity in proportion and same results are obtained.

Adjusting torqued subluxations is a VERY particular, efficient art if done accurately.

In 1906, in our Vol. 3, we laid down a principle of study of observing the way people held their heads in relation to possible subluxations of the atlas or axis. This was extensively followed for some time. Our attention was then pointed in other directions and the viewpoint of then dropped. The position or angle at which patient may unnaturally hold head is no indicative or diagnostic guide to ascertain location, position, kind of subluxation, or which vertebra is involved. It is unreliable because head may be HIGH and subluxation may be either atlas wedge-side-slip, or axis, on that or THE OTHER side. Head may be HIGH on one side and subluxation may be any one of three on OPPOSITE side. Head may be LOW on one side with vertebra any one of three, with subluxation on HIGH side. Head may be LOW and wedge-side-slip may be on HIGH side. A-P and lateral spinographs are THE ONLY final, safe, or accurate guide for efficient work. No rule has been deduced which makes position of head a safe guide to follow. And, even if it were, it would reveal NO information as to WHEN interference was or was not present; whether "adjustment" had or had not restored transmission. If the torque adjustment is given correctly, and the torqued subluxation correctly untorqued, it is surprising to note how quickly the natural abnormal position of head will be corrected. Usually the case is not cognizant of the fact that he

holds his head abnormally, nor will he be aware that its unnatural and abnormal position has been corrected following adjustment.

In every torque, the position of condyles of occiput is shown to be frequently off-balance on normal articulations with articular facets of atlas. Sometimes the head is rocked forward of articular facets, or posterior. The adjustment, when correctly analyzed and delivered, will so right the position of atlas that the occiput will fit naturally and normally back into its position. Whatever merit may lie INDIRECTLY in any "condyle adjustment" or "cranial adjusting" is brought about by an INDIRECT method of approach to attempting the correction of the direct at a distant point; sort of a "remote control" job. It is easier and far more lasting to locate the direct and adjust it.

With a right high wedge-side-slip or a left high wedge-side-slip, the tendency of the axis is to follow thru to the right or left with high side. For instance, with head high on right, with occiput low on right, with atlas high on right, axis following thru with atlas, SPINOUS PROCESS OF AXIS WILL BE TO RIGHT OF MEDIAN LINE.

If atlas should be a border-line case, and you would make a mistake and call it an Axis PRI by preference, adjustment of axis from PRI would have a tendency to drag atlas thru with it, in adjusting axis from PRI, drawing atlas to left, and taking it from being a right high wedge-side-slip. Same would be true in opposite terms. If we had a LEFT high wedge-side-slip with axis spinous process being to left of median line, adjustment of axis spinous process as a PLI would tend to bring atlas thru to right, and tend to indirectly correct its position to right.

If, however, we had a right or left low wedge-side-slip, described in following terms: head is low on right, occiput is low on right, atlas is wedge-side-slipped to right and is high on right, axis spinous process as a PLI would tend to drag atlas thru to the mistake of judging the subluxation to be Axis PLI, and adjusting axis FROM PLI, would tend to carry atlas thru with it and adjust it more TO right, which is side to which atlas is side-slipped. This adjustment would carry atlas wedge-side-slip TO right worse, and increase interference between magnum foramen and atlas. Reverse would also be true. If we had a left low side-slip, then axis spinous process would be to right of

median line. To adjust axis from right, as a PRI, would tend to carry atlas thru with it, and would increase left wedge-side-slip character of atlas and would increase interference between magnum foramen and atlas. Comparatively little harm is done if a mistake is made by selecting axis from right on a left high side-slip, or from left on a right high side-slip; but great damage can be done by selecting axis on a low side-slip, if axis is wrong vertebra.

REVERSING ATLAS AND AXIS RULES

"Atlas rule" and "axis rule" are laid down time and again in this work. When strictly followed, there is at the command of every person, scientific application of location, position, presence or absence, and when of the absolute specific of THE cause of all dis-ease.

a. Is it possible to have violations of these rules which are assuming the absoluteness of law of a specific of THE cause of all dis-ease?

b. Is there a rule by which we can violate either atlas or axis rule by adjusting from reversed side, opposing the rule?

c. Will symptoms, acute or chronic, develop which determine? If such exist are they reliable or capricious?

d. Can patient be relied upon to feel a correct difference, in reversed symptoms, which, correctly or incorrectly felt or spoken, can prove necessity for reversing atlas or axis rule?

e. Is there any descriptive feeling patient can tell chiropractor; or, questions chiropractor can ask patient, that patient can understand sufficiently well from a chiropractor's demands, to answer, which justify chiropractor reversing atlas or axis rules?

f. Can chiropractor palpate or use other external sense means, without aid of other external device, to ascertain accurate known reason for reversing atlas or axis rules?

g. Suppose patient has spinograph and it reveals wedge-side-slip and is adjusted; and later supposition exists that atlas and axis rules should be reversed, will another spinograph show REVERSED direction, thus giving tangible evidence between two intermediate indeterminable dates which would justify reversing atlas or axis rules?

h. Will there exist reversed direction and location of NCM readings, which as evidence, would lead a chiropractic thinking mind to a justification of reversing atlas or axis rules?

To date, answering all questions, rules ARE NOT to be reversed, IF ALL elements in equation are correctly used, interpreted and corrected. If spinograph is properly taken, correctly interpreted; if NCM is properly used and correctly interpreted and adjustment is competently and efficiently given, there is no occasion that CAN exist that justifies either atlas or axis rules being reversed in ANY case.

Few, however, understand and apply ALL elements correctly, competently, efficiently and honestly. Some elements are usually minus or plus; diluted or in essence; few give an adjustment to accomplish the ultimate objective. The strongest professional link in chain of elements is spinograph; NCM is weaker in its place; and weakest is adjustment which is more often less than it is.

This lack of being, in every element, a chiropractor, creates conditions wherein I am satisfied atlas was either adjusted from wrong side and wedge-side-slip of atlas made worse; or, atlas was pushed or shoved from side of wedge-side-slip to opposite side creating opposite wedge-side-slip; or, axis was adjusted when it should have been atlas; or, axis was wrongly interpreted and adjusted to low side increasing atlas wedge-side-slip.

Closely observing and studying application of atlas and axis rules, I have known a few cases where I am confident atlas was overpushed or over-shoved beyond its abnormal wedge-side-slip position to an adjusted normal dead center position over to opposite abnormal wedge-side-slip position. Other cases have been known where other conditions mentioned did exist. Adjustment of these cases, from reversed direction in violation of atlas and axis rules DID justify and DID correct conditions which we were certain were created by excess quantity of direction of motion from abnormal position on one side to abnormal position on opposite side.

Instead of cited cases being a "reversal" of atlas or axis rules, they are a verification, except in variation that we did not stay on THE side all the time to which it WAS subluxated.

Even tho rarely, when are we to know when atlas rule is vio-

lated? When we have over-adjusted or we have adjusted axis from wrong side?

Conclusions were reached by checking every known element, studying its efficiency, competently. We asked ourselves: was patient properly placed for spinograph; was spinograph correctly read; were NCM technique and readings carefully made and interpreted; was adjustment a shove, push or an adjustment in fact; was torque used in opposite direction correcting all THREE directions; was speed used or was there a lack of speed; and, lastly, of little importance, what does patient describe by way of difference in way he felt making proper and due allowance for adaptative corrections as against creation of new symptoms. As a rule chiropractor doing work is least competent to check himself on any or all. If he were, he wouldn't have done them wrong. If mind thru which HE thinks WAS correct, he COULDN'T do any or all wrong. Therefore necessity of introduction of "pro" mind to check detail. Every chiropractor owes it to his practice to once a year close office and take himself to a professional checker who can and will check his detail.

There are times, even tho rarely, when atlas or axis rules should be reversed; meaning that we would adjust towards point of wedge, say to R. wedge-side-slip and into right side; adjust into blunt end of wedge toward point. Such instance would be A CORRECTION OF WRONG DONE by excessive adjusting (if a shove or push can be so called) too much from point of wedge.

HIO Chiropractors report: "Once in a while I have a miracle case—a severe chronic pathology that got well remarkably rapid. Those cases I give the least number of adjustments to, often only ONE."

The Chiropractic reason was obvious. Spinograph was correctly taken, correctly interpreted, NCM readings were correctly interpreted, Chiropractor's approach was correct and his delivery just right. He did what was necessary, and he stopped at EXACTLY the right time, adjusting only so far and no more. Innate response was exact, recoil was a perfect reality, THE vertebral subluxation was specifically repositioned at RIGHT place, FIRST time. An ADJUSTMENT had taken place. Nothing MORE was necessary. Nothing MORE needed to be done. Nothing

MORE was done. Innate, being wholly free, worked with rapidity in "curing" dis-ease—the same rapidity with dis-ease that she does daily with normal function when healthy.

"One-adjustment miracles" are the exception. They should be—and potentially can be—the rule. Some Chiropractors have ONE such a year. Others have several a month. Frequency varies according to ability of Chiropractor who applies the elements. Such should be the goal with EVERY case. Any science which can apply in ONE case can be applied TO ALL, if elements in quantity and quality are ALWAYS the same. Cases we fail on are often-times those we over-adjust in our over-anxiety to do too much too rapidly, not knowing when to stop. Not content to let Innate take her time, WE think it necessary to hot-house and force-grow the case under artificial conditions.

More usually than not, our average "adjustment" is "just another one of those pokes in a neck." We jab away day after day, accumulate a wrong position with increased pressure following. When any case needs "many adjustments" and they come with too frequent succession, you are NOT giving AN ADJUSTMENT. More than likely, not being AN ADJUSTMENT, it is OVER-adjusting. If it isn't the one, it can be and usually is the other.

If case appears to drag or seems getting worse (providing it is not normal retracing or constructive adaptation taking place), you can be reasonably assured that you ARE over-adjusting. That case should have received ONE adjustment and gotten well. You have given "many" close together and therein may lie THE trouble. If spinograph analysis is correct, direction correct, then YOU did NOT give AN ADJUSTMENT. You have been pecking away and in so doing accumulated a too-much-opposite-direction-position of vertebra, increased the inter-magnum-atlas-foramen pressure or increased the interference by shifting odontoid more back into neural canal, etc. Answer to that problem is, look for and adjust from opposite to that to which you have been "adjusting," moderation being as essential in correction to not over-adjust that.

Example: If you have been "adjusting" Axis PRI (true or false) and it has been over-adjusted, reverse to Atlas from L.HI and you will note change. If it was Axis PLI, then Atlas R.HI.

If you have been adjusting Atlas from L.HI, reverse to Atlas from R.LO or to Axis from PRI. If adjusting Atlas from R.HI, reverse to Atlas from L. LO or to Axis from PLI. (I have not gone into the S. or I. directions, altho you must). Several contradictory elements enter: "How can we adjust to a direction from which there is no subluxation that can be listed from a spinograph? Let us say spinograph plane-lines list L.HI, ASL and now you tell us to adjust from R.LO." Only so far—AND NO FARTHER—than is necessary to correct damage you have done by over-adjusting. And DON'T over-adjust the over-adjusted vertebra. That is not only possible but VERY probable for "adjusting" a mistake from L.HI by correction from R.LO would be a simple matter to throw it back to its ORIGINAL position of L.HI and make ORIGINAL subluxation worse. "WHY or HOW can we re-correct a re-adjustment on Atlas from L.HI when spinographs show and prove subluxation IS Axis PRI true, and was NOT atlas at all?" The answer is: THE subluxation IS Axis PRI true; THE subluxation that should be corrected is Axis PRI true, but in your pecking away, day after day, jabbing away on a stiff-arm-shove, you have been shoving axis TO LEFT, raising it on left side; and in so doing have been pulling, pushing, or dragging atlas into a LEFT HIGH WEDGE SIDE SLIP. In attempting to correct: AXIS, you threw ATLAS out of normal position. Moral: Next time correct AXIS and quit before doing damage to position of atlas.

Poor adjusting, accomplishing no good even to the extent of not changing the position of the subluxation from wrong to right position, could be and might frequently be established as a basis of thought for reversing the rule. That over-adjusting happens is true. That the subluxation rule should be reversed is true. That it will happen oftener with shove-adjusters than with recoil-adjustments is true. Great care and much caution must be used to not over-work this over-adjusting rule in too many cases.

The only time atlas rule is reversed is when atlas or axis rule WAS followed and has been OVER-adjusted, either as to frequency of short direction; few times with excessive direction quantity; or where too often rightly adjusted on too low readings.

Examples:

a. You get 2 pt. or more NCM readings regularly. You try to check them out with daily shoves or pushes thus accumulating a quantity of direction of movement which gradually keeps shoving or pushing atlas to opposite direction.

b. You get 2 pt. or more NCM readings regularly. You try to check them out with great excess of push or shove, even tho not given daily, with great excess of quantity of direction of movement beyond center to opposite side.

c. You get 2 pt. or more NCM readings the first day. You check it out with an original recoil adjustment. Subsequently you get less than 2 pt. readings, feel that you must "do something" and begin "adjusting" when you should have let it alone.

At present writing, if ALL elements are correct, I know NO case that would justify ANY chiropractor violating or reversing either atlas or axis rule.

Let me hypothecate three possible cases of right and wrong to illustrate:

a. Monday.

Spinograph. L. HI atlas subluxation

NCM—2 L. reading

Adjustment. Recoil. ASL.

Tuesday.

Clear

No adjustment

Wednesday.

Clear

No adjustment

Given time, case gets well.

Maybe a few more adjustments. Maybe not.

b. Monday.

Spinograph. L. HI atlas subluxation

NCM—2 L. reading

Push or shove from ASL.

Tuesday.

1 L. reading

No "adjustment"

Wednesday.

2 L. reading

Another push or shove from ASL.

Thursday.

1 L. reading

No "adjustment."

Friday.

2 L. reading

Another push or shove from ASL.

Given time, case may accidentally get well, may remain the same, or may get worse. ADJUSTMENT has not been given. Readings have NOT been checked out.

c. Monday.

Spinograph. L. HI atlas subluxation.

NCM—2 L. reading

Push or shove from ASL

Tuesday.

1 R. reading.

No "adjustment."

Wednesday.

2 R. reading

Is it L. HI or R. LO?

At this juncture, let us divide our case into two procedures and see what happens and how evidence can deduce facts.

Thursday.

Spinograph shows L. HI or ASL

NCM proves 2 R. reading

RECOIL adjustment FROM ASL

Raises reading to 3 R.

This proves atlas has been shoved or pushed from ASL to R. LO., possibly ASR or AIR.

Let us analyze other procedure, backing up to Thursday.

Thursday.

Spinograph did show, on Monday an atlas L. HI—ASL.

Where is it now, with reversed readings? That's the question.

NCM proves 2 R. reading

Working on the principle that the shove or push DID reverse atlas from L. HI to R. LO possibly ASR or AIR, suppose we reverse adjustment.

RECOIL adjustment FROM R. LO, possibly AIR.

Completely checks out reading

Remains clear.

Given time, this case should get well assuming that nothing more is done wrong and assuming further that in correcting R. LO, AIR, we do not again shove or push it back beyond dead center to L. HI or ASL again.

CHAPTER XIII.

THE TAILOR-MADE ADJUSTMENT vs. HAND ME DOWN PUSHES



HAND-ME-DOWN SUITS are cut, sewed, patterned, whole-saled, retailed, and sold in wholesale lots, all alike, and sold to wholesale people who are very much unlike. Fat men, tall men; thin men, short men, buy them as they are. 1,000 men, 1,000 suits. Men are fitted to the suits, ready-made. Because they are wholesaled, they are cheap; made cheap, sold cheap. **TAILOR-MADE SUITS** are cut, sewed, patterned, and are sold one by one and fitted to the man. Each suit is individual, special for the man who is to wear it.

Instead of squeezing differently shaped, and different heights of men into ready-made, hand-me-down suits, all machine made and alike, and turned out by thousands, none of which fits except by accident, we now call in the tailor; have him measure each man to his individual height and shape, no two of whom are alike; cut the cloth to fit each man, and make the suit to fit the man.

Chiropractors in previous days thot of an atlas in terms of ASR, AIL, etc., in various positions, as just that, each being like every other subluxation of same direction—all come alike, all to be adjusted alike. Chiropractors placed their nail hand somewhere “up on the neck,” “around the atlas somewhere,” thinking of one atlas as like all atlas subluxations. Wasn’t it an atlas?

The average Chiropractor has been selling **HAND-ME-DOWN** adjustments. They are cut, patterned, wholesaled, all alike; and sold to sick people who are very much unlike. 1,000 sick people; 1,000 adjustments. Sick people are fitted to the adjustments, ready-made. The exceptional Chiropractor has learned or is learning that adjustments must be tailor-made; cut, sewed, patterned and must be sold one by one and fitted to the subluxation. Each adjustment is individual, special for the person who carries a subluxation; no two adjustments fitting each other, because no two subluxations are exactly alike.

The average Chiropractor thinks of an Axis PRI (or other

subluxation) as an Axis PRI, each Axis that is PRI being like every other Axis that is PRI; all come alike; all to be adjusted alike. When this average Chiropractor places his hand on the back, he thinks of one Axis PRI in Mrs. Jones, as like the Axis PRI in Mrs. Brown. Isn't it an Axis? And, isn't it PRI? Subluxations, to his understanding, come in wholesale lots, in wholesale form, to be delivered in wholesale, to a wholesale group of people who walk around under different names. When he gives an adjustment, as he understands it, it is like all other adjustments; so much hands on so much back; so much push at so many places. The average adjustment of the average Chiropractor is just a hand-me-down; they are delivered from the wholesale school to the jobber-student who peddles them retail to the sick multitudes in wholesale quantities. Naturally this wholesale service IS cheap. The adjustments fit in cheap manner onto an expensive subluxation; hence cheap health service is the net result.

The exceptional Chiropractor has learned or is learning that the torqued subluxation and torque adjustment must be tailor-made; each adjustment built for each particular subluxation in this individual person who carries a subluxation unlike any other.

Study your lateral and A-P spinographs. There are no two torqued subluxations wherein the three directions are always of the same relative and comparative quantities of degrees of positions. Suppose "P", "R", and "I" could be based on a 100% subluxation quantity-position basis. "P", in one case could be 20%; "R" or "L" could be 30%, and "I" could be 50%. In another case, "P" might be 40%; "R" or "L" could be 20%, and "I" could be 40%. Both ARE PRI or PLI, but each of the three directions of DIFFERENT degrees. Obviously, you couldn't wholesale a hand-me-down adjustment for both alike, and accomplish the normal demanded tailor-made correction. No two subluxations of either Atlas or Axis, in any of their various possible subluxations, are ever alike in quantities of the various three torqued directions; hence, each adjustment must be tailor-made for each subluxation. If "P" were 10% subluxated, it should not be 30% adjusted. If "I" were 70% of the

total direction torqued in its subluxation, it should not be adjusted 30% of that direction.

(Illustrations 8 and 9 show normal plane lines. Illustrations 116 to and including 125 express this idea of degrees of same kind of subluxations, as applicable to atlas and axis. Study them in relation with this text.)

To tailor-make each adjustment requires FREQUENT study of Mrs. Jones' spinographs before giving Mrs. Jones her adjustment for Mrs. Jones' subluxation. By frequent study of Mrs. Jones' spinographs, you gain the picture in your mind of the varied percentages of three different directions of subluxation in Mrs. Jones before giving Mrs. Jones HER tailor-made adjustment. As you SEE Mrs. Jones' individual subluxations, you think of those percentages of three differing directions of Mrs. Jones' subluxations; you photograph them in your mind; and as the picture, so are your hands directed accordingly to manufacture and cut a tailor-made adjustment for Mrs. Jones. In this way you fit adjustment to subluxation and not subluxation to adjustment. Tailor-made torque adjustments are individually builded; they individually accomplish individual requirements of individual subluxation. They must be individually adjusted. Torqued subluxations cannot be wholesaled and thrown into back bones of the human race, in wholesale form, all alike.

The more spinographs a Chiropractor studies, both A-P and lateral, in sets of same person, the more he deciphers and understands torqued subluxations of atlas and axis and the more he becomes convinced that no two torqued subluxations, even of same direction, are ever exactly alike. He might have 200 PRI true axes, and no two will be alike. It will dawn into his consciousness that EACH torqued subluxation is individualistic; different from all others; that each torque adjustment is also individualistic and must be manufactured especially to fit that subluxation.

(Study all various individual kinds of subluxations listed under latter Chapters, bearing on either atlas or axis subluxations, the more you will become convinced of this fact.)

No Chiropractor who conducts an office practice can remember the individualistic torqued subluxations from day to day or week to week; nor can he repeat individualistic torque adjustment of various cases that constitute his office practice from day to day and week to week. In addition to this in-

ability to keep the direction-value constantly in mind, that case will return day after day, week after week, checking daily, without the necessity of an adjustment. Some day that case will come in and the check will prove necessity FOR an adjustment. No memory is sufficiently perfect to recall detail of THAT torqued subluxation or to remember sufficiently to be able to duplicate THAT torque adjustment necessary to fit THAT torqued subluxation; hence the necessity that is constantly arising in our minds to refresh our minds of the specific evaluations of each of three directions of subluxation to fit equivalent evaluations of each of three directions of adjustment.

With that necessity in mind, let me suggest an ideal arrangement to overcome this problem:

(Illustrations 132 and 133 were taken as samples to illustrate what we mean. Every vital item in the picture is essential, viz., a spinal column, view boxes, spinographs, adjustic drill stool, adjusting table; a Chiropractor, a Chiropractic patient. All should be in CONSTANT use, daily on every case to be adjusted.)

1. When that day arrives that your NCM readings prove the necessity for an adjustment, do this:

2. Have two reading view-boxes, hooked up for restudy of the spinographs of your case now before you.

3. Have close by your rubber-top, adjusting drill stool.

4. Take A-P and lateral views of THAT case.

5. Put them in view-boxes and restudy them, refreshing your mind of its individualistic characteristics.

6. Have these view-boxes directly in front of your rubber-top adjusting drill stool.

7. Then and there, observe and study evaluations of the three possible degrees of the three different quantities of directions of THAT torqued subluxation; and WHILE STUDYING THE FILMS BEFORE YOUR EYES, go thru an adjustic drill, untorqueing the torqued subluxation ACCORDING TO THE SPINOGRAPHS UPON WHICH YOU ARE NOW GAZING.

8. After giving a few "dummy" torqued adjustments, upon the stool,

9. GO TO YQUR PATIENT AND GIVE IT EXACTLY AS YOU WORKED IT OUT ON THE DRILL STOOL AS YOU EXACTLY SAW IT IN THE FILM IN THE VIEW-BOXES.

This should be established as a regular daily form ON ALL CASES, when they need an adjustment. You will be surprised to see HOW MUCH MORE PERFECT your adjustments will be delivered; how MUCH MORE EFFICIENTLY it will step-up net results in your case, because you will more competently untorque the torqued subluxation.

The distance between pitcher's plate, in a baseball diamond, and catcher's plate is 60 feet. 60 feet from the catcher's plate, the pitcher puts a "twist" in a ball that goes straight as a bullet out of a gun for approximately 58½ feet; then mysteriously and peculiarly, suddenly when only 18 inches from the batter, the ball "breaks" and ceases to follow that straight line, and "ducks" either up or down, to left or right. The peculiar thing is that the "twist" is put into the ball 58½ feet away, but that "twist" does NOT break into a "twist" until it is only 18 inches away. The batter sees it coming. From the way it is coming, he knows just where it is going to be when he gets ready to hit it; but by the time he swings his bat at where it is GOING TO BE, it isn't there—it has "spit" into a "twist" that "breaks" different than it appeared coming. If that day ever arrives when any pitcher can bring that ball up to 9 inches before it "breaks," he will fool every batter far more than today. For 58½ feet, that ball carried a "twist" while going as straight as a bullet.

The same issue exists in torquing a subluxation. The actual distance between Chiropractor's head, down thru his arms, thru wrists and hands, to nail point, may be approximately three feet; but the actual torque "break" occurs in the last ONE INCH of downward action, occurring under the nail point of the nail hand. The torque BEGINS in thot in the head; it travels down thru action of arms, but it "breaks" only in THE LAST ONE INCH exactly AT THE MOMENT the hand contacts tip of transverse process or tip of spinous process as they transfer force from nail point of nail hand into vertebra to be untorqued. AT THAT MOMENT, IN THAT INCH OF ACTION, the torque twist is delivered which untorques the torqued subluxation. True, the torque is put into action when it is thot in the brain 3 feet away. It is in the arms all the time the arms are in motion; but it doesn't "break" except in that last one inch of PRI, PLI, ASL or AIL action.

Chiropractors in general have impression that if atlas is left, then vertebra must be **SHOVED** to right; if anterior, it must be **SHOVED** to posterior; if superior, it must be **SHOVED** to inferior. He places his hands and delivers A **SHOVE** which he hopes will be an adjustment. Imagine a pole sticking in ground, to be driven **INTO** ground with a pile drive coming in contact. Visualize that pile driver making contact with **SPIRAL CORK-SCREWING TWIST** at split second it contacts, before it springs away. It did not **SHOVE** pole in three directions, yet it **MOVED** downward, around, and to right, etc., a movement brot about by a **THREE-DIRECTION MOVING TRANSFERENCE OF FORCE, WHICH TWIRLED POLE IN ITS MOVEMENT.**

Detail is important in untorquing torqued subluxations. Any "minor" detail is just that important that as long as it exists it keeps the player from becoming champion; which, if corrected, will make him champion. It is told that Bobby Jones was runner-up for golf champion for several years. A "pro" told him that if he would move his left foot 2 inches, in his stance, he would be champion next year. He did, and he was! It is attention to detail that makes the difference between dubs and champions. The average Chiropractor slaps his hands down on a back, any place, any way; pushes many bones many ways, carelessly, and wonders why his case doesn't get well while some other Chiropractor can take the same case, give **ONE** adjustment, **ONE** place, **ONCE**, and get him well without further service. It is the difference in studying accuracy and competency to detail that makes **THAT** difference. Every Chiropractor has many details carelessly lost in the shuffle. And, what is worse, constantly slipping and getting worse. He needs a "pro" to check him, to tell him to do this, that, and the other thing, just this way or that way, to get him into championship form; and then he too can say: "**THE FIRST CONSIDERATION OF THIS OFFICE IS TO HAVE EVERYTHING DONE EXACTLY RIGHT.**" Doing **EACH** detail **EXACTLY** right, will make him a champion untorquer of torqued subluxations. Some day he too can be A **HOLE-IN-ONER**. Every Chiropractor needs return to The PSC Pre-Lyceum, every year, for four weeks of B.J.'s "pro" checking.

Pursuant to this idea, I wish I could find out, or know, or

use some method which would express in quantity that which exists only in an abstract sense and, while with quantity, is always without that quantity factor being within our reach.

Let a student study 1,000 PRI axis torqued subluxations, he will come to the conclusion that no two are of the same quantity of misalignment in same directions. To list the adjustment as "PRI" is to make it appear that all 1,000 should receive a common hand-me-down adjustment. One may be more lateral than another; another may be far more inferior than some others, etc. How then can we express ourselves? When we refer a case from one city to another, from one Chiropractor to another, how are we to indicate to him how much of each direction to give in his adjustment to properly tailor-make his adjustment for this particular torqued subluxation which is not like any other?

Modern writers indicate their estimated value on motion pictures by giving them an A, on up to AAAA.

Let me suggest the following for torque adjustments:

If the basis were 100% and each were divided into equal quantities, then "P" would be $33\frac{1}{3}\%$; "R" would be $33\frac{1}{3}\%$, and "I" would be the same. Thus should I indicate that adjustment as "PRI" it would mean that, in my opinion, it should be adjusted as much "P" as it would be to "R" and "I".

Should I list the adjustment: P x

R xx

I xxx, it would say that it

should be adjusted "P", but the adjustment should be TWICE AS MUCH from the "R" as from "P" and three times as much from "I".

So, a table could be approximated something like this:

"P"	"R"	"I"	OR	"R"	"A"	"S"
P x	R x	I x		R x	A x	S x
P xx	R xx	I xx		R xx	A xx	S xx
P xxx	R xxx	I xxx		R xxx	A xxx	S xxx

In this way the pluses would indicate the variations in direction to which additional direction must be added to properly and accurately correct direction and quantity of adjustic delivery to efficiently "set" odontoid process back into its fovea

dentalis and thus Chiropractically untorque the torqued subluxation.

(The above crudely expresses an idea. If any reader has a better one, we would appreciate having it. Illustrations 8 and 9 and 116 to 125 express this idea of degrees of same kind of subluxations. We portray in pictures what is here difficult to express in words. From Illustration 272 on, same facts are produced on actual spinographic cases.)

How rapidly things change as fundamentals arise and new principles of science are developed and introduced into our work. In former days (and that isn't long ago) we used to "palpate subluxations." We used to think that we could palpate the transverse processes of the atlas and tell whether it was or was not subluxated; and, if so, which way. Our primary direction, in palpating the atlas, was to palpate the transverse process to see if it was Right (R) or Left (L); whether it was Anterior (A) or Posterior (P) was secondary. We have learned recently, since this torque work has assumed greater importance and has revealed more scientific information, that it is IMPOSSIBLE to palpate ANY subluxation (either atlas or axis) with ANY degree of accuracy or reliability. A careful check-up of The PSC spinographic laboratories with my most careful palpation proves 80% of mistakes. Can it be wondered why we do not now and cannot rely upon palpation as being an efficient method? Today we rely 100% upon what the spinograph reveals. Spinographic pictures, taken accurately, reveal an absolute reproduction of what is internal.

Even present day spinographic interpretations force us to change our method of listing vertebral torqued subluxations. Under palpation methods we listed laterality primarily; anteriority or posteriority secondarily; and superiority or inferiority thirdly; thus RAS or LPI. Under spinographic analyses of torqued subluxation interpretations of atlas, we know that the ONLY directions atlas CAN BE subluxated are ANTERIOR and to left or right; so A is now listed primarily first. This A (anterior) subluxation can be, secondarily, S (superior) or I (inferior). Any atlas that is torqued either AS or AI is either of these on the L (left) or R (right). The listing today, then, would be as follows: ASL; AIL; ASR; AIR.

Atlas—ASL

AIL

ASR

AIR

The day was when a Chiropractor

- thot a vertebra was subluxated
- thot it was producing a pressure upon nerves
- thot it was interfering with transmission
- thot he knew where it was
- thot he was giving adjustments
- thot when he shoved them, he shoved them at
right place, right direction, right time
- hoped the patient would get better.

Those days are GONE!

Now a Chiropractor has a way of

- KNOWING where interference is
- KNOWING when interference is
- KNOWING the three directions of his kink,
twist, wrench, torque locked vertebrae
- KNOWING what directions to deliver to un-
kink, untwist, unwrench, untorque, unlock
the vertebral subluxation.
- KNOWING whether he has or has not corrected
it
- KNOWING there was or was not a restoration
of transmission
- KNOWING whether case is or is not getting
better.

He has scientific methods of checking subluxation both before and after. He can KNOW whether he has unlocked the health reservoir "of the Kingdom of God that is within us" by unlocking its cause of interference.

ADJUSTING TABLE IS ESSENTIAL IN STAYING-PUT ADJUSTMENTS

Each of following essentials is VITALLY necessary to build up that adjustment with that extra something with staying-put value:

1. An NCM—to determine LOCATION of interference

2. A SPGH—to ascertain POSITION of vertebra at location interference
3. The toggle-recoil-Innate adjustment
4. THE KIND OF AN ADJUSTING TABLE TO ACCOMPLISH THE OBJECTIVE.

Four elements comprise the complete and perfect Chiropractic kit-bag:

1. X-ray spinographs; correctly taken and correctly interpreted.
2. NCM accurately used and accurately interpreted.
3. Chiropractic adjusting technique art, efficiently delivered.
4. An adjusting table on which all focalizes into competent adjustments honestly delivered.

It is this last point I now outline. You can't change any element by addition or subtraction; the quantities, by plus or minus; the qualities, either in essence or dilution, or vary the sequence and make the law work AS A LAW equally applicable to all cases alike.

ALL elements must be there. TABLE is one essential ingredient. I know Chiropractors who TRY to practice HIO and contend that everything they do is in strict accordance with HIO work, and yet "I don't get the staying-put value." Upon inquiry, I find they try to give "adjustments" thru, on, and because of feather beds, which spoils every essential ingredient in the toggle-recoil, Innate adjustment.

For years the Chiropractic profession who knew better, have placed their profession in jeopardy by placing themselves at the mercy of suggestions offered by patients who knew no better. Today there exist adjusting tables builded by patients who knew not the needs of a Chiropractor. The PATIENT wanted a table TO PLEASE THE PATIENT, consisting of big, wide, heavily soft-padded, over-stuffed feather beds; over-lain with air-cushion doodads; plastered with thingamajigs to push forward and pull backward; gadgets to lower this and raise that. Under-slung furbelows with thingamabobs on top—all of which have been paralyzing the Chiropractor's ability to deliver a correct, accurate, efficient, competent, and honest adjustment. To please comfort of patient, he was sacrificing delivery of health, via adjustment. In exact ratio as he introduced feather-bed and air-cush-

ion to make it "soft" for patient, he made it "hard" for himself to give an adjustment. No adjustment, no results. No results, a mixer was born!

The average Chiropractor permits his patient to tell him what kind of an adjusting table he wants to take an "adjustment" on. He wants something soft, fluffy, easy, comfortable, that doesn't hurt; that lulls him to sleep, etc. To that end, we have the big, heavily-padded Griffin table that reminds one of a feather bed. Then there are the recent air-filled, rubber, inflated pads that lie on top of the ordinary, heavily-padded table. Between all of this, we have many kinds of belly supports that hang between the front and end sections of a divided table. Some of them are mere slits or strips of leather; some are on hard and stiff springs, and are supposed to give up and down to fit the shapes of abdomens that protrude into them. NONE OF THESE CAN MAKE POSSIBLE THAT KIND OF AN ADJUSTMENT WITH THAT EXTRA SOMETHING, WITH STAYING-PUT VALUE, THAT MAKES IT POSSIBLE.

Since 1923, the PSC has had the courage to reconstruct the Chiropractic structure from theory to science; from palpation to spinograph; from guesswork to NCM; from treatments to HIO; from guess-so to scientific knowledge Chiropractic. SPINOGRAPH gives CORRECT knowledge of POSITION of subluxated vertebrae. NCM gives ACCURATE knowledge of LOCATIONS of and TIMES of interferences. The "adjustment with that extra something with staying-put value" makes possible EFFICIENT Chiropractor ability. And now comes AN ADJUSTING TABLE BUILT BY A CHIROPRACTOR TO MEET THE DEMANDS OF CHIROPRACTIC.

If you try to be a HIO worker, all else may be perfect. IF YOU TRY TO GIVE AN "ADJUSTMENT" on any of kinds of tables mentioned above, your work will fail for want of proof to prove it. Don't blame HIO IF you fail to secure staying-put value of an adjustment; for if it isn't such in fact, it CAN'T stay, BECAUSE IT HASN'T BEEN PUT; AND IT HASN'T BEEN PUT BECAUSE YOU WASTE TIME TRYING TO GIVE such on a feather bed, which isn't possible.

After extensive, clinical-laboratorical, scientific research, we come TO THE UNALTERABLE CONCLUSION that in knee-

chest posture with chest on head end of front table, solidly padded, can such results be attained. I use that kind of table. I would not use any other. A recoil-toggle, INNATE adjustment cannot be secured any other way.

THE B. J. SPECIAL ADJUSTING TABLE is built low. This permits perfect balance for average individual. It is better to be too low than too high. The average adjusting table now on sale or in use is too high to permit any balance. The knee-pad is built on floor; is adjustable forward and backward, altho rarely necessary to be changed. Space between knee pad and front piece has been built to allow plenty of foot room to permit chiropractor to get close to the table for perfect balance. Space under front table permits free access to foot room, vitally necessary to perfect delivery of adjustment. Front pad on front table is solid and is so curved in padding that it permits rest for upper chest on rear portion and location forward for head, creating a dip which permits FLOATING NECK space between to permit Innate recoil for atlas or axis. THIS IS VITAL to a correct adjustment of wedge-side-slip of atlas. Front table top is narrow which permits chest to relax and arms to drop on side which gives firm contact.

THE KNEE-CHEST HARD FRONT PIECE MAKES IT MOST POSSIBLE, in table devices. Patients do not know this; neither can they be expected to know it; yet they too frequently dictate terms for taking adjustments, and spoil all by asking for feather beds. YOU, WHO KNOW, must determine table as well as NCM, SPGH, or any other essential to getting them well.

(See Illustrations 137, 138 and 139.)

The B.J. SPECIAL has no feather-beds, no air-cushion rest couches. No thingamabobs, thingamajigs, gadgets, or furbelows. It is not designed to sleep on, rest on, give massage on, nor can it be used for rectal dilations; nor is it a diagnostic examination table. It was not built to please patients. No patient's opinion, counsel, or advice was asked in its construction. IT IS A CHIROPRACTIC ADJUSTING TABLE—nothing more, nothing less! It was built TO PLEASE B.J. THE CHIROPRACTOR so HE could give better adjustments with a better adjusting table. It is a PRIVATE table, built for his PRIVATE use, to meet his PRIVATE scientific demands.

The B.J. SPECIAL adjusting table was built in every particular upon specified CHIROPRACTIC requirements, plans designed to make possible specific scientific adjustments in accordance with instructions laid down in this book. It is used by B.J. exclusively. Chiropractors who desire to give HIO CHIROPRACTIC adjusting service will find EXACTLY what they need in THIS table. Few tables now on sale or in Chiropractors' offices make that possible.

The profession is permitted to enjoy the B.J. kind of Chiropractic service B.J. the Chiropractor uses on the Chiropractic table BUILT FOR B.J. BY B.J. for his personal, private, professional use.

CHAPTER XIV.

WHY!



WHY should the superior 2 cervical vertebrae be so essential that, wrapped around them is the cause of every dis-ease possible of the human race? WHY should the superior 2 cervical vertebrae be so essential that they could contain a torqued malposition of their relationships that could create themselves into THE CAUSE of every human dis-ease. WHY should the 2 superior cervical vertebrae be so essential that I am forced because of facts justifying, in saying that the only thing that any human being can ever do for another human being, to restore health to dis-ease regardless of location in his body, must be done at this location exclusively? WHY should the 2 superior cervical vertebrae be so important that facts warrant my making the statement that nothing done at any other place in the human body is of direct value in the restoration of health? WHY should we be compelled to emphasize the supreme importance of this location to the exclusion of any other vertebral segments of the spinal column?

The answer is simple: the articulations between occiput and atlas with their wedge-side-slips; between atlas and axis with their atlas subluxations between occiput above and axis below; between axis and atlas above with their fovea dentalis and odontoid process contain the mystery as well as its solution. As many years as we have worked with, studied, adjusted spinal columns, we have never realized the mischief created in destruction of human health and life, as with this singular peculiarity that is not found connected with or between any other two vertebrae. As much as we have studied and researched the spine, until recently none realized that this singular process on the axis contained the true solution to the specific for the restoration of all health to all organs of any human body.

One difficulty I find in instructing this question, even amongst Chiropractors who are supposed to know spinal columns better than other distinctively specialized separated types of students is that they do not sufficiently know NORMAL osteology.

In The Palmer School of Chiropractic is the finest, largest

anomalous, traumatic, pathological, osteological collection in the world. Thousands of specimens are at our command, all once living in a human body. Each specimen has been so thoroughly studied that they are as old friends. This collection has been in the process of being gathered for 30 years. Its actual value possibly would be not less than \$150,000.

In this collection, you will find normal complete skeletons by the score; skeletons with the original skull, atlas, axis, and cervical vertebrae; saying nothing about the balance of the skeletal frame-work. You will find skulls by the score, separated and not connected with their original cervical vertebrae. You will find spinal columns by hundreds; and single groups of cervical vertebrae; also single atlases and axes by hundreds. I mention this to impress the fact that your author knows his normal osteology, having spent thousands of hours getting acquainted with these specimens. And yet, notwithstanding this unparalleled opportunity to know osteology, the importance of this odontoid process has escaped our diligent observation of its connection in the Chiropractic causative and corrective picture until the early spring of 1930; the full importance and amplified understanding of the torqued subluxation and torquing an adjustment not being revealed to the Chiropractic profession until the Lyceum of 1933.

Assuming that our reader KNOWS his osteology would make the setting down of these facts easier; but, having instructed several thousand Chiropractors to this new idea, the one stumbling block to a correct and clear understanding is based on the fact that FEW DO know normal osteology as regards articulations between occiput and atlas; atlas and axis; axis and 3rd cervical vertebrae—beyond that reducing in importance the farther you descend.

(May we suggest that, in absence of such understanding, you observe carefully Illustrations 3, 4, 5, 6, 7, 8, and 9.)

The occipital condyles should articulate on the anterior portion of the superior of the atlas. In the majority of sick people it will be found anywhere but in normal apposition, in articulation to where it belongs normally. This becomes, NOW, an important item of study.

The skull has a normal position in which it should be held

as regards uprightness, laterality, anteriority and posteriority. In the majority of sick people, it will be found anywhere else but in normal position. This becomes, NOW another important item of study.

The untorquing of atlas upon axis; or axis upon atlas, adaptively creates conditions above and below that are worthy of observation and study, but fortunately do not need direct correction.

As a CAUSE, the torqued subluxation creates related conditions superior and inferior to itself which, in the past, have been a source of observation and study which has led us astray from the vital fact we always sought. In the past, we spent much time studying other parts of the spinal column, spending as much time on atlas and axis as we would have upon any other two vertebrae.

The study of the torqued atlas or axis is bringing to light much new information. For instance, the articulation of occiput with atlas. When normal, the condyles of the occiput articulate on the anterior two-thirds of the superior of atlas. When normal, the planes of the occiput and atlas will be parallel to each other, the head sitting approximately level. When the atlas is the vertebra torqued in the subluxation, the occipital condyles may be found resting ON anterior two-thirds of atlas but "racked rocked" either forward or backward, head being either down or up; in other words, not articulating perfectly on anterior AND posterior portions of articulating facets of atlas. When atlas is the vertebra torqued in the subluxation, occipital condyles may be found sitting level IN center two-thirds of superior surface of atlas, thus being posterior of normal position. When atlas is vertebra torqued in the subluxation, occipital condyles may be found resting "racked rocked" in posterior two-thirds of atlas, head leaning either forward or backward. Sometimes occiput is found "racked rocked" so far posterior that parts of the condyles are off articulation with any part of atlas.

The PLANE LINE of the occiput, in comparison with plane line of atlas, may be parallel; they may converge anterior or posterior, as viewed from a lateral spinograph. From an A-P spinograph, they may articulate level; or one, on either side, may be compressed down on one side and elevated on the other;

one side being compressed, the other raised out of normal articulation.

The torque adjustment OF ATLAS corrects misalignment of occiput regardless of which direction or position it may have assumed adaptatively.

The torqued axis subluxation will also create a distortion between axis and atlas which will distort position of AXIS AND OCCIPUT, in which event atlas AND occiput will be more nearly aligned on plane lines that will reestablish normal relationship between atlas AND axis.

The atlas has a normal position in which it should "rock" when in perfect articulation with occiput. Yet it is rarely found in that position. It is either inferior on left side; superior on right side; the anterior arch may be superior against skull or very much inferior from that skull. The posterior arch may be superior against skull or very much inferior from that skull. No matter what its position abnormally, it does seriously affect the relative position of odontoid as it plays that spinal canal inside of the bony ring of that atlas; and thus does create pressure upon the spinal cord, or multiple of its nerve fibres as they pass out and through inferior from the brain.

A study of normal relationship between articulations of condyles of occiput with atlas

—articulations between atlas and axis on zygapophyses

—articulation between odontoid and fovea dentalis

shows that if all three are in NORMAL articulation, foramen magnum of occiput AND neural canal of atlas and axis should be EACH DIRECTLY ABOVE THE OTHER.

The articular surfaces on occiput are located to left and right rims and on anterior one-third of rims of magnum foramen. Articular surfaces on superior surface of atlas are located on left and right rims and on anterior two-thirds of rims of atlas.

A close study of position of atlas in its articulation with condyles of the occiput proves that any general deviation from normal articulation, with atlas subluxated ANTERIOR and superior, or ANTERIOR and inferior; or any rocking forward or backward of atlas from its normal articulation with occiput, is sufficient to decrease size of neural canal, especially between posterior

arch of atlas and magnum foramen immediately superior to it.

If occiput and atlas are approximately on same plane, little occlusion occurs between atlas and occiput. If atlas becomes torqued anterior and superior, it throws occiput adaptatively posterior and inferior; throws posterior arch of atlas inferior and occludes canal between inferior of posterior arch of atlas and superior of posterior arch of axis. If, in addition to this last named position, axis is torqued posterior and inferior, it not only produces last named occlusion, but also one of odontoid posterior into neural canal.

A close study of position of odontoid process of axis shows it fitting UP INTO AND ON anterior portion of neural canal of atlas, it being long enough in its upward extension direction to FIT UP TO SUPERIOR MARGIN of anterior arch of atlas.

A further careful study of anterior arch of atlas shows that articular surface on posterior of anterior arch of atlas proves it to be JUST INFERIOR to anterior margin of foramen magnum which is just superior to it.

A further careful study of odontoid process of axis, as it fits UP INTO AND ON anterior portion of neural canal of atlas proves THAT IT IS LONG ENOUGH in its upward extension direction to FIT UP TO superior margin of anterior arch of atlas and just inferior to anterior margin of foramen magnum which is just superior to it, so that in reality odontoid is JUST INFERIOR to a portion of open foramen magnum DIRECTLY ABOVE IT. Obviously, IF ODONTOID PROCESS OF AXIS IS SUBLUXATED POSTERIOR, OR INFERIOR, OR POSTERIOR AND INFERIOR, it brings odontoid process DIRECTLY POSTERIOR INTO DIRECT PATH OF SPINAL CORD AS IT PASSES INFERIOR out of foramen magnum on its way down into neural canal of atlas.

Correspondingly, any deviation of atlas either anterior and superior or anterior and inferior, with its adaptative mal-position of axis, tends to not only create either of the atlas or axis conditions above, but tends to multiply both of them by pressure of posterior arch of atlas UPON neural canal at its posterior rim as well as pressure of odontoid process INTO the neural canal INSIDE.

The axis has a normal position in which it should "set" when

in perfect articulation with atlas on its superior and with 3rd cervical on its inferior. It may be torqued in its subluxated position so that it is inferior on either left or right side; its anterior centrum may be superior or its spinous process may be inferior, to such an extent that it does seriously affect the relative position of odontoid as it plays that spinal canal inside of the bony ring of atlas; and thus does create pressure upon spinal cord, or multiple of its nerve fibres as they pass out and through inferior from the brain.

(While reading the above fact, we suggest you restudy Illustrations 22, to and including 25. They bring this issue so realistically to optical understanding.)

When it finally dawned into our consciousness that atlas could be side-slipped in wedge fashion between occiput above and axis below creating interference in inter-magnum-atlas foramen and that odontoid process could be torqued in its position into and around in that spinal canal, that these were THE specific causes of ALL dis-ease of the human body, we could hardly believe our conclusions. Thousands of spinographs of the general run of sick people were taken, studied to verify the fact. They did! Thousands of analyses were made of these spinographs and cases adjusted accordingly, to see if results could be attained by the correction of this exclusive conclusion of fact. They were! Many thousands of sick people were spinographed and those spinographs read with this exclusive TORQUED SUBLUXATION principle in mind; and the same thousands were adjusted with the ultimate objective of UNTORQUEING THAT TORQUE to see if the practice of that principle was sound. It was! It was after only three years of constant exclusive research that we finally announced THE TORQUED SUBLUXATION, and THE TORQUE ADJUSTMENT was proclaimed to our profession.

At first we were prone to think it was an occasional condition. We took spinographs of exaggerated positions, thinking we could study conditions, changes, and results better in such cases. In taking unusual, we also studied usual, to be forced to the conclusion that ALL had THE SAME condition, difference being in degree; some more, some less; some with atlas as torqued subluxation; some with axis as torqued subluxation. At first we believed it would be difficult to decipher which and prove

it to our profession. To our surprise, we found it extremely simple; easy to grasp; clearly understood by our profession.

There is a different mechanical motion of rotation and extension between occiput, atlas, and axis. If this motion is confined to within its natural, normal bounds, there ordinarily would not be any possible pressure or interference at this vital place. I doubt if there is one film in 500—either lateral or A-P—which shows these three (occiput, atlas and axis) in normal relation to each other. They all do show, on the reverse, a mal-position in juxtapositions.

In practically all cases odontoid is found posterior into neural canal; sometimes posterior and to left; other times to right. Sometimes it remained in approximate normal fossa location but was shifted in position to right or left. Oftentimes it was as far posterior as to reach center third space between anterior and posterior arches. Take the space between anterior interior surface of posterior ring, and posterior interior surface of anterior ring, and divide it into three equal spaces, and it is surprising to find how many times it is found directly in center third of that space.

Frequently upon a study of a lateral view of cervical region, if head and atlas are on a plane with each other and axis is the torqued subluxation, we find that odontoid process is obliquely crossing neural canal to the extent that it occludes neural canal between inferior surface of atlas and superior surface of axis. Not only is it out of situ, but is obliquely so, thus doing more damage by way of occlusion, pressure, and interference to transmission than if it were just posterior of its normal situ.

I am not unmindful of the fact that if you were to hold a normal occiput, atlas and axis vertebrae in your hands (being certain that they were of same person and therefore possess normal articulations) that it would seem difficult to create, WITH THEM in your hands, that and those spinographic conditions which the eye DOES SEE which exist in the average normal living being. Specimens do not lie; neither do spinographs. That there seems a discrepancy is obvious. The discrepancy, if it be such, does not exist in reality. The bone specimens in your hands possess no flesh. Spinographs do, and

this absence in one case and presence in other, absorbs the difference in seeming fact.

The transverse ligament, which crosses from one pedicle to other posterior to odontoid process in situ, is no hindrance to torqued subluxations which spinographs reveal. This transverse ligament gives, stretches, and is subject to greenstick fractures in living structure same as any other like structure anywhere else in human body. If there be a posterior torqued subluxation of axis, transverse ligament becomes a vital offending element in creation of occlusion, pressure, and interference. As process intrudes into canal, transverse ligament also intrudes directly posterior to it, and thus any misplacement of process also misplaces ligament to an equal extent.

(Illustration 115 portrays this idea clearly. Ligaments in this case are bona fide. Not wax, but normal preserved ones.)

The torqued subluxation not only produces pressure direct of solid substance against the soft, i.e., the odontoid process as well as the transverse ligament; but we must also keep in mind that the vertebra is on a three directional torsion away from normal position of superior vertebra about it, and thus creates a twist of meninges of spinal cord which is no small item in the creation of a constriction circularly and obliquely surrounding canal, thus creating additional interference with transmission of carrying capacity of fibres which form the spinal cord.

In a study of spinographs, a multitudinous and varying series of positions will be observed. The more you study, the more varied they become. They can all be generally classified into certain groups. The varying ones in any particular group will be varied as to degrees of malpositions in that group. But, no matter how many groups are assembled, no matter how varying the degrees in each group; no matter whether the torque be atlas or axis, **TWO FACTORS ARE ALWAYS PRESENT—AN ATLAS SIDE-SLIP WITH INTER-MAGNUM-ATLAS FORAMEN INTERFERENCE, and ODONTOID IS ALWAYS SUBLUXATED INTO NEURAL CANAL.** The more you study the question, the more paramount these become in importance and the more realistic these are. We have discussed the varying positions of atlas wedge-side-slips in a previous chapter. We shall

now outline the possible irregularities of odontoid into neural canal.

The odontoid process can be displaced posterior into the neural canal; to the lateral, left or right, in the fovea dentalis; and if either atlas or axis (preferably and more naturally the atlas) is at oblique angle to the plane of the other (preferably and more naturally the atlas) then odontoid process will present an oblique displacement as well as a posterior displacement of odontoid; any one creating a varied degree of pressure occlusion interference.

The odontoid process can be subluxated to left or right, in canal. When this condition exists, either the entirety of atlas is subluxated anterior from axis; either left or right of atlas is subluxated anterior; axis is subluxated posterior to normal position of axis with atlas and occiput. Study atlas, axis, and 3rd cervical vertebrae. The posterior articulations of axis can move posterior on superior of 3rd cervical, but not the reverse. The fovea dentalis articulation of atlas can be subluxated anterior but not the reverse.

The odontoid process can be displaced posterior into neural fovea dentalis. In this instance atlas and axis may be approximately on a level plane, where atlas may be subluxated to either left or right; or, axis may be subluxated on an approximate level plane to normal position of atlas in relation to occiput.

The odontoid process can be subluxated in neural canal obliquely, laterally. Assuming cervical vertebrae, including axis and all below are normal and head and atlas are superior on one side or inferior on other, then odontoid process would be obliquely to the left or obliquely to right in the fovea dentalis.

The odontoid process can be subluxated in neural canal obliquely, laterally. Assuming cervical vertebrae including axis and all below are normal and head and atlas are superior on one side or inferior on other, PLUS atlas being anterior on one side or other, then odontoid process would be obliquely to left and posterior or obliquely to right and posterior in fovea dentalis.

The odontoid process can be subluxated in neural canal obliquely. The anterior arch of atlas can be superior or inferior. If anterior arch of atlas is superior, posterior arch will be inferior. If anterior arch is inferior, then posterior arch will be superior. If anterior arch is superior, then posterior arch is in-

ferior; then neural canal is impinged between inferior surface of atlas and superior surface of axis. In this condition odontoid is driven into fossa in an oblique direction, superior and anterior, crowding odontoid on the surface of its articulation with atlas and separating them on inferior portion of that articulation. If anterior arch is inferior, and posterior arch will be superior, then neural canal is impinged upon by odontoid process being driven posterior into spinal canal. A lateral spino-graph view of this condition will show an oblique line position of odontoid in which superior portion of articulation between atlas and axis will be separated and inferior portion will be crowded together.

If, in addition, you add an anterior or posterior torque twist of atlas, then you complicate it by adding a third condition, viz., not only crowding odontoid obliquely posterior into canal and creating a superior interference of odontoid upon anterior of cord; but you also create an interference between inferior surface of atlas and superior surface of axis on posterior of cord.

There can exist, then, the following characters of interferences, wherein the torqued subluxation of atlas upon axis; axis upon atlas; either with odontoid misplacement into neural canal, producing direct or indirect pressure, or wherein there is interference superior to either of these because of an adaptative malposition wherein the vertebrae are staggered in relation to the corresponding surfaces between, which off-set creates a pressure where spinal cord must go around perpendicularly to get from above downward.

(1) Anterior and superior torqued subluxation of atlas — interference between staggered surfaces between magnum foramen on inferior of occiput and superior of atlas.

(2) Anterior and superior torqued subluxation of atlas — interference between staggered surfaces between inferior or base of odontoid and inferior of atlas because of an oblique anterior and superior positioned odontoid in its relation with atlas.

(3) Anterior and inferior torqued subluxation of atlas — interference between staggered surfaces between magnum foramen on inferior of occiput and superior of atlas.

(4) Anterior and inferior torqued subluxation of atlas — interference between staggered surfaces between superior or

apex of odontoid, superior of atlas and inferior of magnum foramen because of an oblique posterior and superior positioned odontoid in its relation with atlas.

(5) Any of above, with possible increased combinations, when with torsion to either right or left, making any of them worse, thereby increasing any of above; plus the additional internal pressure of odontoid into neural canal.

(6) Atlas subluxated, with entire atlas to left or right, with odontoid thrown out of its normal articulation on anterior arch creating pressure and interference between staggered surfaces either (a) between magnum foramen on inferior of occiput and superior of atlas; or (b) between inferior of atlas and superior of axis, on either left or right side, or both, between the vertebrae.

(7) Any of the interferences, as mentioned in 6, with possible increased combinations, when with torsion to either anterior superior, or anterior inferior, on either left or right side, making either of them worse, thereby increasing any of above; plus additional internal pressure of odontoid into neural canal.

(8) Possible forcible adaptative distortion of condyles upon atlas, between occiput and atlas, thereby staggering surfaces between magnum foramen on inferior of occiput and superior of atlas, forcing head either

- (a) posterior upon articulations with atlas, throwing head backward
- (b) posterior and inferior upon articulations upon atlas, throwing head backward and inferior
- (c) posterior and superior upon articulations upon atlas, throwing head backward and superior.
- (d) anterior upon articulations with atlas, throwing head forward
- (e) anterior and superior upon articulations upon atlas, throwing head forward and superior
throwing head forward and inferior.
- (f) anterior and inferior upon articulations upon atlas,
- (g) to any of these, the head may be additionally low on the left, or right, thus increasing possible staggered

relative positions increasing interference between inferior of magnum foramen and superior of atlas as the spinal cord passed perpendicularly in between and thru from above below.

(9) Posterior interference of odontoid into neural canal because of an anterior atlas or a posterior axis.

(10) Posterior interference of odontoid into neural canal with atlas left anterior or axis posterior inferior.

(11) Posterior interference of odontoid into neural canal, with atlas right anterior or axis posterior.

(12) Left oblique odontoid posterior into neural canal, with atlas superior or inferior on either left or right side.

(13) Right oblique odontoid posterior into neural canal, with atlas superior or inferior, on either left or right side.

(14) Left oblique odontoid posterior into neural canal, with axis inferior to right.

(15) Right oblique odontoid posterior into neural canal, with axis inferior to left.

(16) Adaptative callous growth cicatrix soft-hard tissue pressure interference at any and all places, either single or multiple, wherever friction of a hard against soft tissue occurs.

The odontoid process is one of two vital factors as subluxated so it exists as an interfering medium in obstructing the neural canal and thus produces pressure upon individual fibres having exits below thru intervertebral foramina and thus produces simultaneous multiple pressures upon individual fibres which compose the spinal cord as it pursues its course inferiorly thru the spinal canal.

Authorities variously estimate the number of fibres that compose the spinal cord. Some say as few as 120 trillion; some as many as 400 trillion. All of these come from the brain, pass thru the magnum foramen, pass into the neural canal and become subject to pressure and interference at magnum foramen, atlas and axis. These fibres pass down and begin segregation on their way to all viscera, organs and tissues composing the human body. Pressure and interference of odontoid at atlas and axis is upon fibres that are continuous thruout the entire length

of the spinal column until such point as they exit. It is not unusual then that you should read this interference heat as of the inferior points of exit from that spinal column. It would be peculiar if such were not true. Owing to its newness, it is not clearly grasped nor understood by those who continue to think in terms of local pressures and local interferences as of the place where readings are observed.

CHAPTER XV.

WHY IS "ONCE A MAJOR, ALWAYS A MAJOR"?



IN The Palmer School of Chiropractic is the finest, largest anomolous pathological and traumatic collection of osteological specimens in the world. Wandering thru this studio, studying thousands of specimens of articulating atlases and axes; examining hundreds of skulls and occiputs, both on complete skeletons and as separate pieces—one comes to the unalterable exclusive conclusion that while bones ARE alike, they have detailed characteristics that are as unlike as opposites could be.

One million people are, after all, all human beings; yet there are no two people EXACTLY alike. They have characteristics which make them GENERALLY alike, yet in detail they differ widely from each other; and it is THOSE DETAILED differences that are the hardest to describe if called upon to differentiate them. As we look at two people, we know one is Frank and the other Francis. We know which is which, because we look and see differences which ARE different to us; but ask me to tell EXACTLY what those differences are, and I find it impossible to put them into words which could convince you what they are, so you could mentally understand if you did not see for yourself.

Each of us, as a single individual, is not alike on the two lateral halves of ourselves. Neurologically we grow as a unit; yet we grow as two people. One left side grew independent of the right half; yet neither side could have grown without the other. Mental impulse supply is bi-lateral. The left eye is not the same as our right; neither are the two sides of our nose; ears. A glove-fitter or a shoe-fitter will tell you the two hands or feet are not the same, and must be fitted independently.

When we grow sick, we grow either larger on one side or smaller on the other. Atrophy is bi-lateral, the same as is hypertrophy. We can be paralyzed on a side and not on other. Ptosis can be of one eyelid and not of other. We can grow blind in one eye; deaf in one ear; lose smell in one nostril; lose taste on one side of our tongue—and opposite side can be normal.

This same difference grows into bones. Take 100 occiputs, atlases, and axes; separate them as separate bones; mix them and you cannot fit any two of them in a mixer-person way. They do not articulate. The difference lies in size, shape, and articulations; the slope of each is different. Certain rules can be laid down about HOW various bones fit into each other, and articulate; yet each set of occiput, atlas, and axis has its own SPECIFIC AND INDIVIDUAL size, shape, and position of articulation for that person. That is why, when a concussion of forces accidentally applies itself to ONE person, with HIS size, shape, and position of articulations, at a certain locality, he has a certain direction of subluxation of a certain vertebra. It can be corrected by untorquing that direction. Let another concussion of forces apply itself, at some future time, on or about THE SAME LOCALITY, and it will produce A SAME KIND of a subluxation of THE SAME VERTEBRA because HE has characteristics that are individual and duplicate themselves. That's but one reason why "Once a Major, Always a Major" which is substantiated by a study of our osteological specimens.

One particular Chiropractic instructor has an explanation of the neurological anatomical distribution between brain and body. His explanation is the recent one offered by recent anatomists. In presenting his views of recent anatomists, he presents the inferior one-half. A PSC instructor, on the reverse, when presenting the same subject from the same anatomies, presents not only the inferior one-half but the superior one-half that goes with it, which is also found in recent anatomies.

Peculiarly, Mother Innate and Father Time don't seem interested in insignificant man who is trying to wrest their secrets from out its hidden recesses; neither do they take time off to ask insignificant man how to build present or future babies. Mother Innate and Father Time have builded all according to a certain pattern which includes a brain, spinal cord, spinal nerves, a vertebral column, an occiput, atlas, and axis, and an axis with an odontoid; with actualities of vertebral subluxations becoming torqued wherein inter-magnum-atlas foramen as well as odontoid process of axis occludes neural canal, produces pressure upon spinal cord, and interferes with

normal quantity flow of mental impulse supply between brain and body, regardless of various explanations offered by various men why try to explain how and why of mysterious things. The torqued subluxation and the torque adjustment occur at the same place, in the same men, regardless of whether explanations offered by any man are right or wrong. In this torqued subluxation and the torque adjustment, it makes no difference to the odontoid process, atlas, or axis, whether any Chiropractor prefers to believe the one instructor with this inferior one-half of the vegetative nervous system; or the other, with his inferior AND superior halves of a vegetative nervous system; Gray's or Cunningham's anatomy with the entire vegetative nervous system, ganglia, synapses, reflex actions, reflex arcs; or my direct brain cell to tissue cell continuity nerve fibre principle. We might, any or all, be right or wrong; the torqued subluxation occurs and can be untorqued in an adjustment and corrected.

The PSC Osteological Laboratories have specimens which show the occiput ankylosed to atlas; atlas ankylosed to axis; axis ankylosed to 3rd cervical; occiput and atlas ankylosed and in same specimen axis ankylosed to 3rd cervical. I do not now recall one specimen which shows all cervical ankylosed from 3rd cervical superior altho I can understand that it might rarely happen. If occiput is ankylosed to atlas, then axis could be major. If axis is ankylosed to 3rd cervical then atlas could be major. If occiput and atlas are ankylosed and axis and 3rd cervical are ankylosed, there would still be a movement for adjustment between atlas and axis in which either could be adjusted, preferably atlas. In such event, adjustment upon atlas would mean movement of occiput with atlas and correction of pressure would be between atlas and axis; or, given time, Innate would break down ankylosis between atlas and occiput if interference was at inter-magnum-atlas foramen. It seems a wise provision that Innate usually keeps one articulation loose for adjustment purposes.

CHAPTER XVI.

SPECIFIC ADJUSTING



IN the study of the torqued subluxation, atlas is either ANTERIOR from odontoid; or axis is POSTERIOR from atlas, thus separating axis FROM atlas. If atlas is ANTERIOR, then anterior arch can be superior or inferior. If anterior arch is superior, then posterior arch is inferior; and vice versa, if anterior arch is inferior, then posterior arch is superior. Atlas cannot be posterior in its entirety, but either side can rotate either posterior or anterior, in which event opposite side can be relatively normal or directly opposite. In other words, one side can be posterior or anterior and opposite side can be neither anterior nor posterior. Any posteriority of totality of atlas would fit fovea dentalis TO odontoid and thereby do NO harm by way of pressure. Any anteriority of atlas, whether it be one lateral side or in totality, would separate fovea dentalis FROM odontoid of axis and subluxate odontoid INTO neural canal and would thereby do harm by way of pressure.

Superficial study of the torqued subluxation, leads an average student to conclude that when one lateral side of atlas is anterior, opposite side must be posterior; that atlas is a rotational vertebra on its odontoid, therefore if either side is anterior, opposite side must be posterior. This is NOT true. In an anterior superior, or anterior inferior subluxation of atlas, on either left or right side, the opposite side can be comparatively stationary, NOT moving in opposite direction. One side being comparatively stationary, with its opposite side moving anterior, superior or inferior, is what separates atlas FROM odontoid. If an atlas moved forward on one side AND the opposite side moved posterior, there could be NO SEPARATION of odontoid FROM its fovea dentalis. It IS that unequal separation that MAKES a torqued subluxation of atlas FROM axis.

In study of torque subluxation, axis can be posterior and inferior, but NOT superior. In listings of torque subluxation there is no anterior or superior axis. If it were possible to have an anterior or superior torqued subluxation of axis, it would fit

odontoid INTO fovea dentalis. To sublunate axis posterior AND INFERIOR is to separate odontoid FROM fovea dentalis and displace odontoid INTO neural canal.

Choice of direction of adjustment must be based on the facts of only two kinds of sublunations, viz.,

(a) atlas, anterior, superior, or inferior, left or right.

(b) axis, posterior, inferior, left or right.

The choice of direction of adjustment rests upon decision as to WHICH ONE is THE torqued sublunated vertebra.

HAS HIO LIMITATIONS?

Its principle is potentially complete. Its specific hypothesis is sound and as an abstract it is right. If the human equation of Chiropractor and patient could be eliminated, it would work in 100 per cent of cases.

As a practice, introducing patient and Chiropractor, it suffers because of their inability to overcome the varying degrees of understanding. Chiropractors may deliver fluctuating values of adjustments. The severity of condition in patient sought to be corrected; chronicity of dis-ease sought to be "cured"; age of patient and time he allows for cause to be restored—all of these and more will limit it in application.

A REASONABLY SAFE EMERGENCY HIO METHOD

"Assuming I have no SPGH or NCM and I am convinced of HIO principle and practice; that I know necessity for accurate knowledge of a R. or L., HI or LO wedge-side-slip adjustment, and I am unexpectedly called to an emergency case. No spino-graphs can be taken, therefore I don't know whether it is atlas or axis; whether it is L. or R., HI or LO. I possess no NCM, and if I did I then did not have it with me, therefore I don't know WHERE or WHEN interferences are. I have none of the HIO foundational facts with which to approach emergency case. I can't well afford to refuse it; I can't honestly accept it. Not desiring to do anything wrong, and wanting to take least chance of error, where shall I give an adjustment, and how?"

1st—THE specific for cause is either atlas or axis. By disregarding balance of spine, you are eliminating waste time, remotely applied, in places that do not effect emergency condition, whatever it is.

2nd—Knowing primary danger resident in doing wrong work on THE SPECIFIC, it is essential to reduce per cent or error to its minimum, therefore I would resort to axis by preference.

3rd—Knowing that to adjust an atlas as a L.LO, when it might be a R.HI, would make wedge-side-slip worse and thus INCREASE interference, and knowing there is no external means of knowing which it is, without spinographs, I again would resort to axis by preference.

4th—Knowing law of averages gives more AIR then L. ASL, then ASR, then AIL, in that order, I can do LESS harm by following axis rule, adjusting INTO LOW SIDE, for there are MORE R. and L. LO's than R. or L. HI's.

5th—Therefore I would quickly judge position of head, finding which side is LO.

6th—I would palpate to verify axis rule to see which side of median plumb line axis spinous process was on.

7th—If head, atlas and axis are LO on left side, I would adjust axis from PRI.

8th—If head, atlas and axis were LO on RIGHT side, I would adjust axis from PLI.

9th—I would carefully check, if possible, to remember my axis rule (if it could be ascertained) to "never adjust according to axis rule INTO a LO wedge-side-slip."

10th—First palpate base of occiput on right and left sides to determine tipping of head, whether it be low or high on right or left. Then palpate axis and atlas for laterality. If axis palpates right and atlas palpates left, atlas is taken in preference to axis, so as not to increase wedge-side-slip. The Opposite is true. If axis palpates left and atlas right, atlas is taken in preference to axis. If head is low on right and axis is left and atlas is left, axis is taken in preference to atlas, following axis rule. If head is on left and both atlas and axis palpate right, axis is taken in preference to atlas. If head is high on right and axis and atlas both palpate left, atlas is taken in preference to axis. Opposite is true; if head is high on left and both atlas and axis palpate right, atlas is taken in preference to axis.

11th—My adjustment would be given with two objectives in view:

- a. To get UNDER axis spinous process and RAISE IT SUPERIOR to throw odontoid process out of neural canal into its fovea dentalis.
- b. By adjusting towards LO side it would, according to law of percentages, drag over atlas from slipped-to side and thus, according to law of percentages, bring it back to center position where it belongs.

According to law of averages, there will be times when you will adjust into wrong or LO wedge-side-slip side, but law of averages is in your favor. (See table of frequency on Page 346 in this book.)

A visitor to A LITTLE BIT O' HEAVEN fainted from heat. Not having time to take spinographs, a NCM reading WAS made and high reading found. Palpation was resorted to, adjustment given according to axis rule. In a minute or two case belched excess gas and vomited half of bucket of material and immediately came out of faint. Case went home feeling normal.

I would use same procedure on epileptic seizures, etc., if called unexpectedly to attend such. If I was a Chiropractor, practicing without SPGH or NCM, that would be my office procedure on ALL cases. I would omit all attention to any other part of spine, confining my attention to superior cervical region and follow that method. Given time, your practice will exhibit two MARKED types of cases: those who get well like miracles—where you accidentally happened to adjust THE cause just right, and those who will get worse—where you accidentally adjusted and made the wedge-side-slip worse. This procedure will soon prove that ALL cases have CAUSES in atlas or axis. It will also prove THE need of ACCURATE, EFFICIENT, COMPETENT, AND HONEST WORK in cases you fail upon.

CHAPTER XVII.

RULES FOR TORQUEING ADJUSTMENTS

We have been working on the twist, wrench, kink, or torque idea for three years; both in clinical research as well as analyzing thousands of X-ray plates.

As a result, there are NINETEEN possible twists, wrenches, kinks, or torques in the superior cervical region.

They are:

1. Atlas anterior. Happens so rarely that we merely mention it.
2. Atlas anterior and superior (AS) Happens rarely.
3. Atlas anterior and inferior. (AI) Happens rarely.
4. Atlas anterior and superior on left. (ASL)
5. Atlas left high wedge side-slip (ASL)
6. Atlas anterior and superior on right. (ASR)
7. Atlas right high wedge-side-slip. (ASR)
8. Atlas anterior and inferior on left. (AIL)
9. Atlas left low wedge side-slip. (AIL)
10. Atlas right low wedge side-slip. (AIR)
11. Atlas anterior and inferior on right. (AIR)
12. Axis posterior. Happens so rarely that we merely mention it.
13. Axis posterior inferior. Happens rarely. (PI)
14. Axis posterior inferior, false left. (PI false L)
15. Axis posterior inferior, false right. (PI false R)
16. Axis posterior right inferior. True. (PRI true)
17. Axis posterior left inferior. True. (PLI true)
18. Axis posterior right inferior. False. (PRI false)
19. Axis posterior left inferior. False. (PLI false)

If the head is low on left, atlas is low on left, axis is low on left, then axis spinous process will be to right of median line.

The axis would be listed as a PRI and should be adjusted to ALS.

In this condition, right hand would be nail hand; right elbow would torque toward you, or inferior; left elbow would torque away from you, or superior.

This adjustment would RAISE axis on left,
 atlas on left,
 head on left, thereby untorquing
 the torque's kink.

If the head is low on right, atlas is low on right, axis is low on right, then axis spinous process will be left of median line.

The axis would be listed as a PLI and should be adjusted ARS.

In this condition, left hand would be nail hand; left elbow would torque toward you, or inferior; right elbow would torque away from you, or superior.

This adjustment would RAISE axis on right,
 atlas on right,
 head on right, thereby untorquing the torque kink.

Two possible variations or exceptions occasionally occur. (False listings).

If the head is low on left, atlas is low on left, axis is low on left, and axis spinous process is LEFT of median line, the adjustment would be given as in the first instance above, as though it were a PRI.

If the head is low on right, atlas is low on right, axis is low on right, and axis spinous process is RIGHT of median line, the adjustment would be given as in the second instance above, as though it were a PLI.

6. At. ASR. Head down on LEFT side of face. Stand on RIGHT side of case. Nail point on RIGHT transverse. RIGHT hand is nail hand.
 Adjustment to LPI.
 RIGHT hand, being nail hand, torques to INferior.
 LEFT hand, being hammer hand, torques to superior.
10. At. AIR. Head down on LEFT side of face. Stand on RIGHT side of case.
 Nail point on RIGHT transverse.
 RIGHT hand is nail hand.
 Adjustment to LPS.

RIGHT hand, being nail hand, torques to superior.

LEFT hand, being hammer hand, torques to inferior.

4. At. ASL. Head down on RIGHT side of face. Stand on LEFT side of case.

Nail point on LEFT transverse.

LEFT hand is nail hand.

Adjustment to RPI.

LEFT hand, being nail hand, torques to inferior.

RIGHT hand, being hammer hand, torques to superior.

8. At. AIL. Head down on RIGHT side of face. Stand on LEFT side of case.

Nail point on LEFT transverse.

LEFT hand is nail hand.

Adjustment is RPS.

LEFT hand, being nail hand torques to superior.

RIGHT hand, being hammer hand, torques to inferior.

Above rules for adjusting directions of atlas sublaxations hold good in wedge-side-slip sublaxations, same as regular sublaxations of atlas. Difference would be in interpretations of films AND instead of adjusting ALWAYS from SUPERIOR side, you would adjust from INFERIOR side where you have a "low" side-slip sublaxation instead of from superior side.

Rule for adjusting wedge-side-slip atlas sublaxation would be:

Adjust on transverse process FROM side atlas has side-slipped TO.

Examples: Atlas right HIGH side-slip. Adjust from RIGHT.

Atlas right LOW side-slip. Adjust from RIGHT.

In the following reference, as applicable to axis sublaxations, note that we refer to "True listing" and "False listing."

By "True" listing is meant:

If the head is inferior on left, atlas is tipped inferior on left, axis is tipped inferior on left, (head is tipped posterior over left shoulder) spinous process of axis will be to RIGHT of median line. This is a TRUE listing of a PRI sublaxation.

By "False" listing is meant:

If head is inferior on left, atlas is tipped inferior on left, axis is tipped inferior on left, (head is tipped posterior over left shoulder) spinous process is occasionally found LEFT of me-

dian line. This is a "False" listing of a PRI subluxation. This would be unusual and not running true to the usual form of a PRI subluxation, notwithstanding we would adjust it as a PRI subluxation.

16. Axis. True listing PRI.

Head is low on left.

Atlas is inferior on left.

Axis is inferior on left.

Axis spinous process is to right of median line.

Subluxation is PRI.

Head is down on LEFT side of face. Stand on RIGHT side of case.

Nail point UNDER right side of spinous process of axis.

Right hand is nail hand.

Left hand is hammer hand.

Adjustment is to ALS with the objective of:

raising left side of head

throwing head forward from posterior

raising left side of atlas

raising left side of axis.

Right hand, being nail hand, torques to inferior.

Left hand, being hammer hand, torques to superior.

17. Axis. True listing PLI.

Head is low on right.

Atlas is inferior on right.

Axis is inferior on right.

Axis spinous process is to left of median line.

Subluxation is PLI.

Head is down on RIGHT side of face. Stand on LEFT side of case.

Nail point UNDER left side of spinous process of axis.

Left hand is nail hand.

Right hand is hammer hand.

Adjustment is to ARS with the objective of:

raising right side of head

throwing head forward from posterior

raising right side of atlas

raising right side of axis.

Left hand, being nail hand, torques to inferior.

Right hand, being hammer hand, torques to superior.

18. Axis. False listing PRI.

Head is low on left.

Atlas is inferior on left.

Axis is inferior on left.

Axis spinous process is to LEFT of median line.

Subluxation APPEARS PLI but is listed as PRI.

Head is down on LEFT side of face. Stand on RIGHT side of case.

Nail point UNDER RIGHT side of spinous process of axis.

Right hand is nail hand.

Left hand is hammer hand.

Adjustment is to ALS with the objective of:

raising left side of head

throwing head forward from posterior

raising left side of atlas

raising left side of axis.

Right hand, being nail hand, torques to inferior.

Left hand, being hammer hand, torques to superior.

19. Axis. False listing, PLI.

Head is low on right.

Atlas is inferior on right.

Axis is inferior on right.

Axis spinous process is to RIGHT of median line.

Subluxation APPEARS PRI but is listed as PLI.

Head is down on RIGHT side of face. Stand on LEFT side of case.

Nail point UNDER LEFT side of spinous process of axis.

Left hand is nail hand.

Right hand is hammer hand.

Adjustment is to ARS with the objective of:

raising right side of head

throwing head forward from posterior

raising right side of atlas

raising right side of axis.

Left hand, being nail hand, torques to inferior.

Right hand, being hammer hand, torques to superior.

We list ATLAS torqued subluxations as superior or inferior,

judged by anterior arch in spinographs; Atlas as high or low, as judged by which side it may have wedge-side-slipped to. Atlas may be superior or inferior, on right or left, without being wedge-side-slipped. Adjustments would be given on left or right transverse process according to which side it may be SUPERIOR OR INFERIOR on without being wedge-side-slipped; or adjustments would be given on left or right transverse process according to which side it may be HIGH OR LOW, being wedge-side-slipped. If anterior arch is inferior, then adjustment would be to superior FROM side analyzed in a regular atlas subluxation. If anterior arch is superior, then adjustment would be inferior FROM side analyzed as a wedge-side-slip.

We list AXIS subluxations as true or false, left or right inferior. We never find an axis superior, either true or false. The reason is plain when we keep in mind that the odontoid is torqued POSTERIOR into neural canal away from fovea centralis dentalis.

IF atlas is torqued ANTERIOR, either superior or inferior, either right or left, this separates atlas FROM odontoid process and throws it POSTERIOR into neural canal. If axis is torqued INFERIOR, either right or left, as judged by position of spinous process, this also separates axis FROM the fovea centralis dentalis and throws it POSTERIOR into neural canal. In ALL ordinary atlas OR axis torqued subluxations, odontoid process is thrown posterior AWAY FROM the articular fossa into which odontoid process should articulate. There are only TWO WAYS by which this separation of the odontoid process from its fossa CAN occur, viz., atlas is anterior of axis, or axis is posterior of atlas. IF atlas is anterior of axis, then atlas is superior or inferior, either left or right, of axis. IF axis is posterior of atlas, then axis spinous process is inferior to either left or right, of median line. That is why you find NO listing of any axis torqued subluxations SUPERIOR. If possible to have an axis torqued SUPERIOR, it would throw odontoid process anterior into fossa where it belongs. That is why adjustment of axes torqued subluxations ARE always given toward the superior.

When there exists a wedge-side-slip subluxation of atlas, we get an occlusion between inferior of magnum foramen and su-

terior of neural ring of atlas with some possible distortion of position of odontoid in addition.

The "torque" is a cork-screw triangular direction, vertebral subluxation, permanently locked in that distortion, listed as Atlas ASL, Axis PRI, etc. It means that the vertebra, when subluxated, was distorted into a three-directional kink, twist, wrench, or torque; unable within itself to correct itself; locked from outside and can only be unlocked from outside. The adjustment is a cork-screw triangular direction, vertebral correction, that will permanently unlock that distortion, delivered in reverse direction. If Atlas is ASL, adjustment would be PRI. If Axis was PRI, adjustment would be ASL. We often refer to the adjustment as a "torque adjustment"; it could also be called "a reverse triangular direction adjustment"; it could also be called "an unlocking motion to a locked vertebra". It is for these reasons that we call particular attention to new interpretation of spinographs. Lateral views give some directions; A-P views give balance. That is why it IS important that BOTH views be taken, for no one view gives ALL directions of a torque, nor would it reveal ALL directions necessary to unlock the vertebra.

CHAPTER XVIII.

FUNCTION FLOWS—DIS-EASE UNFLOWS—HEALTH RE-FLOWS; LIFE GROWS—DIS-EASE UNGROWS —HEALTH RE-GROWS.

The purpose of this chapter is to bring to life the application of all we have taught in previous chapters. All that was didactic. Now comes the application.

—to make real HIO chiropractic principle and practice in lives of sick people who need it.

—to prove that few adjustments are necessary to get even severe cases well, if rightly located, Innate ascertained and correctly adjusted.

—to suggest in tangible form, what is set forth is as applicable for chronic severe cases as for acute mild ones, giving what we teach the severest possible case test.

—to set forth in plain language that having health, losing it, growing dis-ease and regaining health are a matter of growth.

—and to set forth reasons and explain the process.

—to apply all this to one of the worst possible cases that it has been our experience to know wherein accurate statement of daily changes were noted by a mind that understood both the medical and chiropractic problems, as applied to himself after having experienced old chiropractic as well as the new.

—and to make clear to chiropractors as well as patients how and why the new evolution; one adjustment, one place, one way, at right time, may be and often is sufficient and yet prove the great necessity of time to get cases well.

Life is the normal and natural quantity and quality of expressed action in any composite structure builded by an intelligence greater than could be collected within itself during its composite form; as directed with and in the quantity and quality of that expressed action by an intelligence greater than it could collect within itself pending creation, transmission and expression of that expressed action.

Death is the antithesis of life. Death is inactivity in any composite structure builded by an intelligence greater than could be collected within itself during its composite form; possessing no

quality or quantity of action, not being directed by an intelligence born within its composite self, there being no creation, transmission or expression of any degree of action within the human life range.

Further explained; all cellular matter is at all times in electronic, molecular, atomic, vibratory activity within itself and later between itself and others more or less like itself, increasing the organization of action as the structure becomes more organized. Morat covers this question so ably when he says:

"In the living being all the phenomena appertaining to crude matter are observable, BUT THE CONVERSE DOES NOT HOLD GOOD. IT IS OBVIOUS THAT A BEING ENDOWED WITH LIFE POSSESSES CHARACTERISTICS AND PRESENTS MANIFESTATIONS FOR WHICH IN DEAD MATTER WE CAN FIND NO PARALLEL; and the most marked feature distinguishing the one from the other is that of sensibility. Here is brought before our notice a fact of a purely internal nature, ELUDING OBSERVATION as it is generally understood in science, BUT WHICH COMMON SENSE CONSTRAINS US TO ATTRIBUTE TO BEINGS RESEMBLING OURSELVES, WHILE AT THE SAME TIME DENYING IT TO ALL OBJECTS IN WHICH THIS RESEMBLANCE CANNOT BE DISCERNED.

"This attribute, sensibility, cannot in the living being act as a substitute for the energetic phenomena of matter; it is merely superposed to these phenomena, and connected with them by a double reciprocal link. THEY PRESIDE OVER IT in the sense that a subject gifted with feeling must, of necessity, require an object to be felt; and, on the other hand, sensibility exercises a control over these phenomena of energy, inasmuch as though incapable of modifying them as a whole, it can still regulate and control them in their execution of functions directed towards an end of which the living being itself is conscious. THIS RECIPROCAL LINK NOT ONLY CONTROLS THE RELATIONS OF THE LIVING BEING WITH ALL SURROUNDING OBJECTS; IT IS ALSO, and simultaneously, THE DISTINCTIVE FEATURE OF ITS ORGANIZATION. In its development, as much ontogenetical as phylogenetical, it is the living being which is at once both artificer and final cause. From this double link, SO FRAIL IN ITSELF AND YET SO INTIMATE, PROCEEDS THE UNITY OF BEINGS ENDOWED WITH LIFE, and in this organism, where each part depends on the whole, and the whole on each part, a synthesis is affected which confers upon it its individuality. This prodigy of complexity is also a prodigy of unity.

"A SCIENCE HAVING FOR AIM THE STUDY OF A BEING SO CONSTITUTED SHOULD NEVER LOSE SIGHT OF THIS DOUBLE CHARACTER, and more especially when appealing to the methods and general principles of other sciences. Dissociated and brought back to the crude

state of common matter, the primary elements constituting the living being reveal to us in their reactions the same inflexible constancy that characterizes the laws known as physico-chemical; yet, associated in the individual, their grouping and organization display that infinite variety and contingency whence individuality is derived. How can this proceed from that? HOW CAN THAT WHICH IS INVISIBLE IN THE ELEMENT BECOME APPARENT IN THE WHOLE? TO THESE QUESTIONS WE CAN FIND NO ANSWER; but in science as elsewhere, it is always imprudent to run foul of the information given by common sense, and a problem is not solved when one of its terms has been omitted.

"The mind, desirous of being logical, is in fact at first offended by this contrast, and endeavors to annihilate it by evading one of the two points of view. The rigid determinism of purely energetic sciences has been transported, without restriction or selection, into biological science. IN THE PAST, AND EVEN AT THE PRESENT TIME, PHYSIOLOGY HAS OVERLOOKED, AND STILL OVERLOOKS THE FACT OF THE BEING WHICH IT STUDIES POSSESSING SENSIBILITY; AND HAS IN EVERY CASE REFUSED TO ACKNOWLEDGE THIS SENSIBILITY AS A CAUSAL OR CONDITIONING INFLUENCE IN THE DETERMINISM OF VITAL PHENOMENA. It has carefully arranged the balance-sheet of the forces of the organism, while taking no interest in the function which regulates their employment. AS PHYSICAL SCIENCE FINDS NO PLACE FOR SENSIBILITY, NEITHER HAS PHYSIOLOGY ACCORDED IT ONE. THE TIME SEEMS TO HAVE ARRIVED FOR A REACTION AGAINST THESE EXAGGERATIONS. In the living being, just as MOVEMENT DEPENDS ON SENSATION, SO DOES SENSATION DEPEND ON MOVEMENT. In both cases the nature of the link is unknown to us; BUT NONE THE LESS DOES THIS LINK EXIST, and is in biology the foundation of all that distinguishes it from pure physics."

The character of this action ranges from lowest unicellular amoebic movement to highest of multicellular human organized structural movement. "Death" is a transitory involution in passing from organized character of that speed of activity out of the multicellular human range into some lower, slower speed of unicellular activity with less organized purpose.

Dis-ease is any reduction in speed of activity, reducing its organized purpose, within human range of activity, between natural and normal life and death levels. Life is motion. Death is its absence. Dis-ease is a slowing-up process. As we have said in a previous chapter, it is single and simple.

Man has within his living being two intelligences—Innate and Educated.

One is an involuntary gift to his body complete at birth. The other he voluntarily develops from nothing to what we hope will

be something. Morat again puts this question in fine terms when he says:

"The nerve tissue is, like all other tissues, originally formed of cells; but while other cellular structures are usually merely composed of duplicated and juxtaposed elements, it, thanks to the connections established between its component parts, **DISPLAYS A GENUINE SYSTEMATIZATION**. Its study may therefore be carried on from two different points of view; one in which the functions common to all its elements are considered (cellular functions), the other in which the functions special to the groups or systems formed by these elements are taken into account (systematic functions). In this study of nerve tissue the distinction between these two orders of functions is a fundamental one, and the obscurity still enveloping numerous questions connected with this study is partly due to the fact of this distinction being so frequently ignored."

Innate Intelligence is a gift. Educated Intelligence is sometimes developed. Innate Intelligence is greater than Educated Intelligence. Educated is an accumulative collective personality. It gathers in, thru and with the composite form during its existence, between "birth" and "death"; "birth" and "death" being relative terms. Innate Intelligence is greater because not collected during existence of any one composite form; and can be conceded that it might be accumulated in many.

Innate Intelligence is always a present normal known quantity, within itself. In abstract, it is always present, always normal, ready and capable of doing all, everywhere, for the needs of any composite form in which it resides. The known quantity of Innate Intelligence is unknown to Educated Intelligence, no matter how Educated it thinks it is.

The corporeal physical composite form, a by-product of this Innate Intelligence of the mother, is "born," lives and "dies" of a known quantity of organized matter barring operations, amputations and disintegrations.

Between unknown (to Educated) known normal quantity of Innate **ALWAYS PRESENT**, in known normal quantity of a human body thru which it should work, can be a great variation of the presence or absence of one in the other. It is these multitudinous, more or less permanent, fluctuating intermediations that are dis-ease in fact, regardless whether functional or pathological.

"Dis-ease" means "not-at-ease". It is a condition matter finds itself in. Disease is matter not-at-ease. "Ease" is matter in na-

tural, normal rhythmic organized motion; moving at its natural rate in all parts harmonious to each other. QUANTITY OF INTELLIGENT FORCE PLUS QUANTITY OF ORGANIZED MATTER PLUS QUANTITY OF TIME EQUALS EASE OF QUALITY FUNCTION, WHEN ALL ELEMENTS ARE BALANCED.

"Dis-ease" is some Educated unknown quantity of abnormal motion, moving at an unknown unnatural abnormal non-rhythmic speed of action in some part or parts disorganizing smooth running of the organization. "Dis-ease" is where the unknown normal QUANTITY of force IS PLUS OR MINUS producing an unknown abnormal QUALITY of function where time is off normal balance with other two elements with each other, hence dis-ease between elements of time, force and matter. As we said before, it is single and simple.

We refer to "unknown" for it IS to our educated observed senses. We educationally have no known way OF KNOWING the required normal or natural quantity of force, matter or time, neither can we understand their balance to establish healthy function in any part, let alone all the body.

"Dis-ease" as we educationally think we know it, is a GROSS understanding where a gross quantity of force has been unbalanced a gross length of time; where quantity of matter is of large proportions and quantity of time has accumulated to such proportions that its contrast with what our so-called trained educated senses seem to think it should not be, that is not natural or normal. Tumor is an example.

We are prone to observe two gross classifications:

a. Functional dis-eases where we cannot observe abnormal matter.

b. Pathological dis-eases where we do observe abnormal matter. The border line between, to our observed so-called trained senses, is obscure, concealed and beclouded. We think of "nervous dis-eases" as of function minus pathological structural destruction of tissue. We think of "pathological dis-eases" as of destruction of tissue with little consideration given to functional nervous disturbance as its basis.

An electric globe is a simple and single example. We need globe, electricity; the two together create function—light.

The elements are:

- a. globe—matter
- b. electricity—force
- c. time. Globe plus electricity plus time equals light. Light plus time of 24 hours a day, 30 days a month, 12 months a year, with the internal ability to repair and rebuild itself as it deteriorated, would be equal to “ease” of purposeful healthy function. Each element is normally and naturally balanced with each other, and should continue to the normal span of its existence and not “die” a premature “death”—permanent darkness.

If 100% of globe received only
 90% of electricity, out of
 24 hours a day, and this continued indefinitely, 10% “dis-ease” or darkness would exist.

If 100% of globe did not receive
 100% of electricity, out of
 24 hours a day, obviously the globe is not functioning (light) normally or healthily.

Multiply multitudinous possibilities in quantity reduction of flows of electricity, to part or parts not receiving it, by time length such interference exists and you GROW the effects of darkness, “dis-ease.”

In a human body, Innate force cannot be reduced in creation but can be reduced in expression to where destruction of use of matter occurs, which lowers THE VALUE of an hour of living time. Innate force, or Time, as abstracts, CANNOT be destroyed, but VALUE of a workable hour of force and time in human matter CAN BE diminished by reducing its quantity OF WORK delivered which destroys its quality of by-product — health—not delivered. Matter can, as a net result, disintegrate, dissolve or become destroyed by reducing its reconstructive value, per hour, day, week, or year as it accumulates. “Dis-ease” therefore has behind it two fixed elements but work delivered by those fixed elements can be reduced below a normal natural par standard of human existence. In exact ratio as WORK is NOT delivered by fixed elements of force and time, dis-ease exists in inverse ratio.

Quantity of force is fixed. Quantity of time is fixed. Quantity of matter is fixed. The only reducible quantity is energy,

force, mental impulse, etc., as it does not balance itself in and with matter. By reducing that balance in former two, all are reduced in action and "dis-ease" exists.

Force and time, are, in abstract, constants, permanent conditions. Force and time, are, in concrete substance of man, inconstant, not permanent conditions. Only matter is transitory. "Ease" is in matter of man only as force and time balance. "Ease" can and does exist in force and time, without matter. When "dis-ease" exists IN MATTER, quantity of matter CAN BE reduced when quality of its function is reduced to where it dissolves its organized continuity thru disintegration IF a given quantity of force IS reduced in a given quantity of matter in a given quantity of time period.

Human matter, when living, is measured by a time element, the usual three score and ten. It also can be measured by how much does it live while it is holding his structure together, keeping body and soul united. Does he exist, or live? Is he existing in a form of abnormal dissolution or living in a natural form of organization. If he lives, how much does he live, for some people live far more, per hour, than others.

One essential element in all composite natural products is the reparative or reconstructive factor. It is, or should be, ALWAYS at work. While some forces are reduced in quantity, in a given quantity of matter, in a given quantity of time, other forces in same organized body are thru other channels normally at work, in a normal quantity, in a normal given quantity of matter, in a given quantity of time, endeavoring to save matter. So we see some forces cut off, destroying matter; other forces flowing normally working to save matter by rebuilding whatever and wherever possible. If ALL were normal, Innate should not be compelled to rob Peter to pay Paul. To reduce robbing of Peter and continuing to pay Paul is the objective of permitting a normal quantity flow to ALL parts thus regrowing health in ALL parts at ALL times so that organized matter could LIVE the fullest life between "birth" and "death."

Innate, residing in that body, is always "ease". "Ease" is a source. The bodies of almost all human beings contain "dis-ease." "Dis-ease" is a lack of organized expression; a by-product of absence of Innate in some part or parts. An adjustment of

CAUSE OF INTERFERENCE BETWEEN THE TWO makes possible RESTORATION OF ONE IN OTHER, re-creating "ease" from where "ease" IS always an uninterrupted source, to where "ease" WAS NOT, thus rebuilding the "dis-eased" body with "ease" forces.

(See "Cause" and "Effect" under "Definitions".)

(See "When Is a Subluxation." Chapter V.)

"Dis-ease" is a growth, especially in observed form when matter is directly involved, such as tumor, anaemia, etc. "Dis-ease" is an ungrowth of health. "Health" is a regrowth from "dis-ease" back to itself. Growth is forced to introduce the element of time. In a peach seed are dormant potential future bushels of ripe peaches PROVIDING seed is planted in productive food-feeding soil, earth is watered and TIME sprouts seed, grows tree and it matures to bloom and fruit. No thinking person would plant a seed Monday and expect to pick fruit Tuesday. Paradoxically, that is what many patients expect when they go to a Chiropractor. They think because he CAN and DOES find THE cause in an hour, gives an adjustment and sometimes CAN and DOES permanently correct it in a minute and opens the channels so that Innate CAN and IS able to BEGIN flowing in a minute of time, that their "dis-ease" SHOULD BE gone instantly and remain so.

It takes a year to raise a crop of hay. It is stored in a barn that took years to grow trees from which lumber was made. An insignificant match that takes a second to strike into fire, when wrongly applied, burns down barn and its contents in an hour or two. The natural growths of years are quickly destroyed.

It took 280 days to grow a set of bowels and store them away in a human body. An insignificant jerk, twist, wrench or slip which takes a second of time, produces a vertebral subluxation, occlusion, pressures, and interferes with function, sets up a fever-fire or can completely paralyze those bowels in an hour or two. Appendicitis or constipation now exists. The work of years of growth of organized matter is set at naught and the expressed purpose of function in that matter is destroyed.

Patient, suffering with fire, can go to a surgeon and have the burning appendix cut out. The patient, suffering with a paralyzed bowel can go to a physician, take a dose of salts and fecal

matter passes more quickly. For the present, he overlooks the fact that he needs that appendix for future work; or, that while bowels moved the obnoxious salts once, his bowels are still paralyzed. No CURE has been rebuilt by removal operation or stimulation salts in either instance.

The patient, suffering with a burning appendix, goes to a chiropractor, receives adjustment, mental impulse is restored quickly in its OPPORTUNITY to reflow to appendix, that no one second, minute or hour completely puts out fire, but that it is a BEGINNING process of rebuilding — and then wonders WHY he doesn't receive the QUICK relief that he received with the operation, with assurance that he never can have more trouble because appendix isn't there. He little realizes that WHAT HE RECEIVES from a chiropractic adjustment, even tho seemingly little, done quickly, without inconvenience of hospital, operating room, nurses, etc., is the BEGINNING of a PERMANENT normal and natural restoration of action IN THE APPENDIX that will be left within him for its natural future use.

Patient, suffering with a growth of chronic paralyzed bowel, goes to chiropractor, receives adjustment, mental impulse is restored quickly in its OPPORTUNITY to reflow to paralyzed bowel, that no one day, week or month completely puts all those bowels into 100% normal permanent action, but that it is a BEGINNING process of rebuilding—and then wonders WHY he doesn't get up next morning after first adjustment with the QUICK relief he received from salts. He little realizes that WHAT HE RECEIVES as the result of a chiropractic adjustment, even tho seemingly little, done quickly, at little cost, without inconvenience of continuing taking daily salts is the BEGINNING of a PERMANENT normal and natural restoration of action IN THE BOWELS that will continue naturally for years without further attention.

The patient suffering with intense pain can take morphine and deaden pain temporarily by desensitizing feeling quickly. He little realizes that pain is sensation based on condition of pathology in matter which took time to grow and as long as it exists, pain is a consequent sequence. Some patient going to chiropractor receives adjustment which makes possible a slow but steady rebuilding of pathology of matter from which pain

was a sequence; and, in exact ratio as pathology returns to normal pain ceases to be and NORMAL feeling is restored. Instead of attempting to deaden excessive and unnatural feeling (perhaps thereby creating a dope fiend) the chiropractor makes possible a normal par restoration of feeling.

Disease is medically recognized as possessing concrete substance elements, in cause, diagnosis and treatment. Diagnosis of disease possesses as many concrete substance observations as multiplicity of square of alphabet contains words. Many organs and viscera may go wrong in single or multiple; many combinations are possible with endless varying observed recognitions and titles applied. Disease, diagnostically, is therefore a complexed subject in its simplest form.

Diagnostically, recognition of disease is fraught and surrounded with innumerable insurmountable complications. Symptoms are blind and pathologies are deep-seated and unobservable. Reliability of what symptoms exist depend upon peculiarities, eccentricities and idiosyncracies of patients. Reliability of what pathologies exist depend upon previous education and present ability of a physician to interpret what patient says, his skill in correctly using diagnostic instruments and his inward guessing values in knowing what it all amounts to if he does recognize them in their true stage of existence. Given a certain case, with definite and fixed symptoms, send him to 20 physicians and state exact symptoms to all alike, and he will have issued 20 different names for 20 different diseases in 20 different organs and receive 20 differing treatments.

Diseases exist by thousands. Treatments exist in many times that number as every disease has its various individual treatments according to its theory of cause. Generically and exactly speaking there is NO SCIENCE in medicine. It is try and seek, cut and fit, and try again. Medical men are empirical and dogmatic, with empirical and dogmatic minds and theories in their views on treatment of any disease, few agreeing. If its cause is a germ, germs must be killed. If cause is chemical, the chemical prescription is changed. If disease cannot be cured from within, then it must be removed if removable.

Prescription of drugs is based, not on any theory OF CURE in the sense of restoration of normal health to any organ. It

is hoped that the drug or combination of several may STIMULATE or INHIBIT function that something may be done to something which will change something in some way to bring about something that may simulate health. Acknowledging the *vix medicatrix naturae* principle in theory, he ignores it in practice except in the hopes that he can do something with concrete substance which will make IT in the abstract (whatever "it" is) do something to the concrete organ which will produce a temporary change, which he hopes is health, which he further hopes can be prolonged long enough to make it permanent. At best, whatever change exists, is temporary. The drug has a temporary changed value and must be repeated time and again to repeat the change, eventually losing its temporary value; after which dose must be increased in volume or another drug substituted of greater potential or volatility.

How different the chiropractic approach. Life is INTERNAL energy at work in matter. Matter cannot possess motion without internal force to move it. Force which moves human matter comes from within the human. When force within cannot reach the matter without which forms us, then matter slows down in its rate of functional activity and "dis-ease" is present. Dis-ease is of single and simple construction—slowing down of functional rate of motion of matter.

Vertebral subluxation produces pressure upon nerves which convey force from the brain wherein generated, to the organs, muscles and tissues of body. Produce pressure upon nerves and quantity force flow is reduced thereby destroying the normal quality of its by-products—function and health.

Disease has adaptative features for man lives and works as an entity unity. If liver slows down its activity, it upsets other chemical balances to which it played an important part. Other adaptative symptoms develop which play into any one diagnostic picture. How simple chiropractic—when there is but ONE dis-ease; regardless of organ, character of lack of action, or combination thereof in one or more organs.

The chiropractor acknowledges ONE dis-ease; ONE cause; ONE source; ONE adjustment necessary at ONE place, with designed desire to correct it ONCE. Finding that ONE place; giving ONE adjustment; restoring flow of ONE force; from ONE

source; thru ONE channel predestined; whatever existed abnormally and unnaturally, will, sooner or later, be restored to normal functional speed of action and HEALTH is the ultimate and unequivocal requisite.

Medicine, diagnosis, prescription, complicate human bodies and human existence. They create additional burdens to man's already over-burdened sick-ridden body. Chiropractic with its ONE location to find cause and one place for adjustment simplifies understanding of the same human living being by reducing and eliminating the burden of man's already over-burdened sick-ridden body.

It necessarily must take many years of study to attempt to understand so complicated a structure as medicine. It necessarily does not take many days or weeks to understand the simple principle and practice of chiropractic. Take a mind not prejudiced by previous medical concepts that can appreciate greatness of a simple principle and practice of chiropractic and a chiropractor is already in the making. Take a mind that studies the muddles of medicine and it may take years to unscramble the mixture of its complexities hoping to arrive at something conclusive, eventually arriving back to the point from whence he started, only to find medicine a hopeless subject. Take a third mind trying to fit the complexities of medicine into the simpleness of chiropractic, or, fit the simplicity of chiropractic into the muddles of medicine, and you have a mixer-practor that does discredit to either and both.

The usual chiropractor feels he must meet the already understood medical concept of sick people by catering to their medical ideas about diagnosis, treatments, etc. He panders to systems and methods that HAVE failed; which he as a chiropractor KNOWS have failed; which the patient ADMITS have failed. Presence of sick person IN chiropractor's office is prima facie observance. Yet patient anticipates, expects and asks chiropractor to repeat failure systems and methods with its lack of results. The usual chiropractor seems to think it necessary to repeat failure systems and methods to pander to patient. THE LESS I KNOW ABOUT DISEASES, SYMPTOMS, PATHOLOGIES, DIAGNOSIS, DIAGNOSTIC INSTRUMENTS AND HOW TO USE THEM, THE BETTER CHIROPRACTOR I AM AND

CONTINUE TO BE AND THE QUICKER I AM ENABLED TO GET SICK PEOPLE WELL; PROVIDING, I AM A CHIROPRACTOR AND KNOW ALL THAT I CAN AND SHOULD AND HAVE PLACED AT MY DISPOSAL TO KNOW, ABOUT KNOWN CHIROPRACTIC. Obviously, if I DON'T KNOW much about CHIROPRACTIC I am compelled to fill the void by pandering what little I may repeat out of medical books about medicine, diseases, diagnosis, etc., to make the patient think I know more about what he thinks he knows about himself. When any chiropractor attempts to practice any phase of medicine he deceives himself and his patient and restrains himself from learning chiropractic and his patient from receiving it and its results.

The single MOST important chiropractic item to recovery of health, is adjustment. It is the single WEAKEST link in our professional ability. Capable in all other respects, many chiropractors fail to deliver IT. The obvious necessity would be to build themselves, thereby IT, to a high stage of efficiency. Peculiarly each THINKS HE IS efficient. Failing to get chiropractic results with his consistent-efficient-inconsistent-inefficiency, he fills the void with medical substitutes.

The next two most important items are mental impulses and time. Time is naught without mental impulses to rebuild change. Impulses, even if possible, are naught without time to re-create re-built health. With these at work we can expect correction of dis-ease. It MAY BE necessary to have thousands or millions of mental impulses flowing for thousands or millions of seconds (4 weeks being about one and a half million seconds) to ungrow dis-ease to re-grow health. These two elements ARE internally efficient and DO NOT DEPEND upon efficiency of chiropractor. These are WITHIN the patient.

The giving of adjustment is the most SIMPLE altho MOST necessary thing a chiropractor does. It is easy for an average patient to understand WHAT a chiropractor does, WHY he does it, at THE PLACE it is done. From that point on complexities of lack of understanding enter. The case little realizes that maybe scar tissue may have to be broken down—THIS TAKES TIME; or, he may not understand that spinal cord has shrunk and it must rebuild back to normal size before ANY signs of

health can be expected—THIS TAKES TIME; or, that excessive growths or destroyed dis-eased tissue structure at periphery of nerves such as tumors or cancers may have to be rebuilt to full capacity use—THIS TAKES TIME. It takes LITTLE TIME TO GIVE an adjustment. IT DOES TAKE TIME for Innate to ungrow dis-ease and regrow health.

Cause, being abstract in form, is created in a second of time. Subluxations are practically instantaneous in creation. Physical effect, being in concrete form, takes time to grow. Adjustment, being abstract in form, even tho done in concrete matter, can be corrected sometimes in a second of time. Physical effect, being in concrete form, takes time to ungrow. The average patient does not understand this difference in time between what the external chiropractor does in the patient's internal body, and what the internal Innate in the patient's body must recover in that patient's body. If he did, he could and would get well in many instances where now he refuses mentally to understand and take time to permit his body to get well.

From the above it is understood that application of chiropractic is far-reaching to conditions to which names are applied by diagnosticians. How far reaching is it? Are there types of cases that should be left alone? There are some I believe advisable to put into that class under a broad construction. I have known individual cases that have come within following classifications, that have been adjusted and have gotten well. It isn't that these cases CAN'T get well; but one of judgment of construction as to strength of conviction of chiropractor and his inability to utilize chiropractic; or, his desire to assume the safe side of a marginal risk that he might assume did he take them.

Applying names to spinal column, I suggest following generally be left alone:

fractures

dislocations

fracture-dislocations

dislocation-fractures

tuberculosis of vertebrae in advanced stages

caries or necrosis of atlas or axis region

atlas or axis heavily impregnated with mercury or other substances which destroy the contiguity of their solid structure.

On the reverse if there is a fracture, dislocation, fracture-dislocation, dislocation-fracture, tuberculosis of vertebrae in advanced stages, caries or necrosis of vertebrae other than atlas or axis; or, if some vertebra or vertebrae below axis are impregnated with mercury or other substance or substances which might or has destroyed the contiguity of their solid structure, then judgment must be used as to whether to assume the risk of mobility of removing case to table for adjustment.

Fractures, dislocations of other vertebrae do not introduce occlusions, pressures or interferences as much as is imagined. A case is cited in Chapter V wherein case of fracture-dislocation at 12-D. followed by paralysis to all parts below, was adjusted at axis and got well of paralysis but continued with fracture-dislocation.

We can conceive of no other one more practical case to personify all we have said, above, than the following history of Dr. McGillvary. Himself a PSC chiropractor, passing thru all stages of understanding of medicine and chiropractic by contrast; passing thru failure stages of old chiropractic to success steps of new chiropractic; having kept a day by day written recording of his case (a complete file of which is in my possession); where what he now says is not a matter of vivid suffering recollection but a written record made as of the date it occurred—all this makes it possible for him to now set forth a clear, concise and complete exposition of the growth of health that once existed, the ungrowth of dis-ease as it grew, and the regrowth of health as it recurred.

The case history introduces many facts:

- a. He proves that he ran the gauntlet of everything in medicine and surgery.
- b. His case was handled by "specialists" and some "of the best" the medical profession possessed.
- c. He grew from bad to worse under their "scientific" administrations.
- d. He was "adjusted" many places, many ways, a la chiropractic meric system, growing worse.
- e. He finally was ADJUSTED at right place, at right times, in right way and regrew well.

f. Proving that it was not necessary to be "adjusted" many places, various places, to grow well.

g. Proving further that it was not necessary or advisable to be "adjusted" every day, many places, various places, to grow well.

h. Proving still further the full contention set forth in this chapter that transition from health to sickness is an ungrowth of health, a growth of dis-ease; as well as a regrowth from dis-ease back to health.

The case history is a vivid exposition of a clear understanding of the mind that suffered and passed from life to a living death and back to live once more. Altho long, we commend its study to those who are sick who need understanding he possessed and here writes for that purpose.

A HOLE-IN-ONE- MIRACLE

Case History of J. W. McGillvary, 11 Broadway, Bayonne, New Jersey

Although some of this history may seem too long and covers several years, I feel that it will be a great help to those who suffer as I have and to those who meet such cases in their daily practice. In 1921 I was in extremely good health, weighing 150 pounds.

I developed varicose veins in the right leg and thighs. Being told that rowing exercises would overcome this condition, I joined the Bayonne Rowing Association, taking part in many regattas during the next two years. Rowing did not help the condition—only made it worse so that the vein bulged out more than ever, I had to wear an elastic bandage to keep the vein from bursting.

In May, 1923, I developed sciatic neuritis in the right leg. Took adjustments with little results. Being booked to compete at Springfield, Mass., I decided to have the veins surgically removed. Admitted to the New York Post Graduate Hospital about June 3, 1923. The operation was to be the following day. For many years I had been subjected to chronic case of constipation, often going two weeks without a bowel movement. I do not know how many days this had gone on at the time of entering the hospital. The evening I was admitted, the nurse gave me a large bowl of licorice. The next morning no action having resulted, I was given a two quart enema. No results. Orderly said that was all right. In such a condition I was operated upon that evening at 5:00 p.m. The doctors and nurses worked desperately all night to save my life. I have no recollection of what had gone on.

The following day about noon I became conscious and tried to get out of bed. The internes and nurses rushed at me, forcing me to lie down and

keep quiet, but would not tell me why. When they went away, I attempted to sit up again and was warned by the other patients not to attempt sitting up as I had almost passed out during the night previous. They told me that I had almost strangled to death. I then noticed that my tongue had three holes in it and was badly swollen. The holes were put in my tongue during an attempt to break up the spasms which I had gone through while unconscious. I noticed several large tanks of gas around the bed which had been used to give me artificial respiration.

The morning after the operation, the orderly asked for a urine specimen. I was unable to urinate. He was about to catheterize me when I became aware of a rubber tube protruding from the rectum. I told the orderly about it. He said it was left there the previous evening. The next evening following the operation I developed a very bad case of Acute Decubitus, one on each side of the buttocks, directly over the sacro-iliac articulations. These newly developed lesions almost drove me insane. They could do nothing to relieve my pain except give me hypodermics of opiates and hypnotics. I was given about eight hypodermics a day. The buttocks were swollen on both sides and also as hard as a rock. They bolstered me up on seven pillows so as to try to ease the pain. The hypodermics failed a short while, so they gave me opiates by mouth. My arms became covered with green spots where the hypos were inserted, except after two days the condition died down, but left me with terrible case of sacro-iliac pain and double sciatica extending down both legs. I was discharged from the hospital in this condition.

As time passed, the pains began to grow worse. I started to take adjustments regularly in 1924, with little results. 1925, I continued to grow worse. In June of 1925 the Bayonne Board of Health tried to force me to accept a vaccination, and because I refused, I was kept in the house under police guard for three weeks. The inflammatory condition of the sciatic nerve became very much increased, and the inflammation invaded the sacro-iliac articulations. X-ray in my possession discloses that about $\frac{1}{4}$ -inch was eaten away. In July of 1925 the pelvic inflammation was so bad that it was impossible for me to sit down. All through 1926 I grew steadily worse. I tried dieting without results. The lumbar region of my spine now began to be terribly painful. 1927 found my condition still worse than ever. Then I went on a fifteen-day fast with no result. I tried hydrotherapy, electrotherapy, massage, psychological suggestions, heliotherapy, physical culture, and a host of other methods with no benefit at all. In September, 1927, I went to the New York Post Graduate Hospital and was examined by an orthopedic surgeon who told me that I had a typical "poker spine."

The muscles of the back and thighs were contracting more and more as time went on, preventing me from stooping over very far. I could not sit down from the time I got out of bed in the morning till I went to bed at night. The dorsal spine then became involved. It got very painful and stiff. I still took adjustments and grew worse. In the late summer of 1927 I was unable to stoop lower than my knees. The back and leg pains

increased as time went on. At the Post Graduate Hospital, I was suffering so badly I suggested that my sacro-iliac articulations be pegged together in hopes that I would have some relief from the pelvic pain. The surgeon advised against doing this. Time passed and in 1928 I was in such a condition that no kind of treatments of any nature helped me. On February 6, 1928, I was in such terrible condition that I was almost insane. Every step was a living hell of pain throughout my entire body. The clothing touching my body would give me terrific pain; each step would produce a hot flash starting at my head and sweeping over my entire body, followed by a drenching perspiration. My legs began to spread apart as I walked, compelling me to go on in a stooped position. This naturally attracted the eyes of all who passed me. I was accused of having every venereal disease possible. I had to go around an out-of-the-way route whenever I left home or came back, to avoid those who watched and followed me. On February 6, 1928, I went to the New York Orthopedic Hospital to get some relief. The Orthopedic surgeon marveled at how I was able to walk in such a condition. When he was finished with my examination, I asked him what he thought was the matter with me. He said he suspected "tuberculosis of the lower spine and pelvis." They wanted me to remain, but not being able to afford the price asked, I returned home. I was no longer able to turn my head from side to side. I could not stoop to touch my knees. In May, 1928, I bought a Philo Burt appliance hoping it would help me. I wore this from May till December when I was forced to go to bed.

The appliance made my life a typical hell. I had to pad the inside of it with bed sheets to keep it from pressing against my left hip bone. By this time I had lost 48 pounds. I still took adjustments with the result that each experience was crucifying. I would turn blue for a minute or two, unable to breathe, due to the terrific muscular contraction that would follow. I had to stand on my toes when I would ride on a bus or trolley car to absorb the vibrations and prevent them from jarring my body. At times, if I should stub my toe I would immediately vomit. My legs were beginning to get stiff and heavy. In June of 1928 I had new X-rays taken. The next X-ray showed exostosis forming ankylosis between the first, second, and third lumbar vertebrae extending upward from the fifth towards the fourth lumbar. At the same time I had another urinalysis made and a diet set which I followed. I grew steadily worse. By this time I was so stiff I could not stoop half way to my knees. My legs were so stiff I could not raise my left foot up to get it over the curb stone. My right leg swung out in a semi-circular manner while walking, and my legs spread farther apart day by day. By this time I could sleep only 2½ hours out of the 24.

I grew weaker but kept going on, hoping to eventually find some way to overcome my sufferings. I took adjustments in the cervical region, but got no results. One night during the first week of December, 1928, I left the house and as I turned the corner I was aware that my walking was at an end. When I took a step and about to take another, my left leg was seized by violent spasms which pulled it behind me. I then went back to the house to bed.

A few nights later, I suffered violent spasms of the spine in the left mid lumbar region, which almost drove me insane. I thought that the spinal bones were pulled out of place due to the terrific spasms that were occurring constantly. Several days later my neck became so that the head was pulled over at one side. It took two people to hold my head at such times. On the 8th of December, as I was forcing myself to reach the kitchen I became as stiff as a board, all over my body. I was dragged back to bed where I stayed until April, 1929. At the end of April I called in an orthopedic surgeon to examine me. When he finished he said, "Son, you have been through hell. You are in too terrible a condition to handle. I have had thirty years' experience in just such cases as yours, but you are too bad for me." He gave me drugs to deaden the pain in the spinal cord and advised me to go to Dr. Fred Albee.

In the New York Post Graduate Hospital I was admitted on May 2, 1929, and placed under Dr. Moorhead, bone surgeon, and a staff of nerve specialists, as well as the consulting aid of Dr. Albee. I was examined and re-examined for three weeks. Four to five X-rays were taken and at the end of May they sent me home with the verdict that I was beyond help.

While in the hospital they especially made many diagnoses, among which were tumor of the spinal cord, Locomotor Ataxia, then finally Osteoarthritis of the spine and pelvis, with spinal fixations throughout the entire spinal column. I was advised to keep away from doctors and to trust that some other method might find relief for me.

After coming home from the hospital I went to bed to stay, growing steadily worse. 1930 arrived, growing worse day by day. My body twitched every moment, more so the lower limbs. Spinal pains and soreness were horrible. My both hip joints started to weld together and with the spinal spasms causing movement of the body, you can imagine the terrible pain I was in. Spinal meningitis developed, involving the substance of the spinal cord and paralysis set in the muscles of the buttocks and the back of thighs. The attacks took place every three weeks, by which time I became as rigid as a board and with my head pulled backward caused my body to arch.

Many times no one could come near the bed or walk on the floor of my room without causing me intense pain. My family thought I was dying and a priest was called to anoint me, which he could not do. The floors had to be padded before anyone was allowed to enter the room. By this time I could move my right arm; the rest of my body was paralyzed. Colitis developed and with each bowel movement following an enema each night, large lumps of solid mucus and blood would pass the abdominal region. The abdominal region burned continually. In November, 1929, my left shin bone opened in two places, then the big toe—all running pus. My legs from the knees down became so burnt that the flesh looked like that of a roasted turkey. This burnt flesh would gradually peel off. By this time I was so thin that a friend actually spanned my waist with his hands and my spinal bones could be easily felt through my abdomen. I was now sleeping 1½ hours out of each 24, always on my back. For four years I was unable to lie on either right or left side. I was unable to turn my head

in either direction, as my neck was rigid. The spine was burning like a continuous fire. Months passed without it being possible to change the bed clothing because of the pain I was in. Even to talk to me increased my pain. On February 8, 1930, I went on an exclusive milk diet thinking it would help me, but with little response. 1930 passed, still growing worse. 1931 about the same. Nothing but the bones and the skin on my limbs by this time. The little ridges on the thigh bones could be felt with the thumb and first finger. The shin bones and the big toe still ran pus. The body still twitched. The spine was more rigid than ever. The abdominal reflexes were completely absent.

The first three weeks of September, 1931, I developed a very severe case of pneumonia. Following this, I felt somewhat better. On Sept. 27, 1931, Dr. Palmer sent a Chiropractor to see me, to see if I could be aided by the new Hole in One method. This Chiropractor never returned, and the following February the Chiropractor friend of mine met this particular person at a gathering in Newark and asked why my case was turned down and why I was not visited and helped if possible. The Chiropractor whom Dr. Palmer sent to me said: "He is too far gone. He is paralyzed and nothing can be done for him." This goes to show how bad my physical condition was at that time.

1932 arrived and I was still the same, the reactions taking place every three weeks; considerable burning of the rectum. At times I would vomit up what food I would eat, and had two hemorrhages during the time I had pneumonia. At times I still continued to believe that a Chiropractor would do me some good. I called in Dr. Myers of Jersey City, who came to see me several times and due to the terrible state I was in, did his best. At the end of the month, I asked him if he knew of anyone in Jersey City who could give me the Hole-in-One method with the Neurocalometer. He said he knew of someone and he would see that my request was complied with. About the 15th of September, 1932, Dr. Myers brought Drs. Bryan and Voza. At that time I was just bordering on another attack. NCM reading was made in an attempt to give me an adjustment. It was not until the 28th of October that another could be given.

On this day the first Hole-in-One adjustment was given. It took three hours to get me out of bed to give an adjustment and get me back into bed, because of the constant pain and the twisted condition of my body with the rigidity of the muscles of the neck and head. On November 19th I was taken by Dr. Bryan in an ambulance to Dr. Schmeelk's laboratory and X-rayed, which showed exostosis from ankylosis throughout every region of the spinal column. The entire cervical region was ankylosed. Three-quarters of the dorsal region and the entire lumbar region, also both sacroiliac articulations united and both hip joints ankylosed.

During this time I was under the care of Drs. Bryan, Hollister, Myers, Trantz and later Dr. Samson.

On the 6th day of December I was lifted out of bed and to my great surprise was able to stand for a few seconds without support. On December 20th, a reaction occurred which lasted for about three weeks.

1933 arrived and on January 24, 1933, I walked around my room on crutches for the first time in four years. I grew stronger, began to gain in weight, began to sleep better, with pain decreasing gradually. I could turn on my right side. The bowel action became more normal. The burning abdominal pain decreased. The infection in the shin bones and toes lessened. My appetite grew better. The abdominal reflexes returned. My optic nerves which were extremely sensitive lost their super-sensitivity. The bowel contents lost the burning seering qualities, twitching gradually decreased, and strength returned to my lower limbs. The reactions decreased in severity and in length of duration.

Another X-ray was taken on March 4, 1933, showing ankylosis breaking up in the neck and in the mid spinal region. Both hip joints had improved a great deal with the right hip joint free and the left hip joint free from the ankylosis.

From this time on, the other doctors previously on the case retired from the case. Drs. Bryan and Voza went on from this time, until today. On both occasions where X-rays were noted, I was brought to the laboratory in an ambulance on a stretcher. The first time it took four hours to be X-rayed; the second time, about two hours.

Only ONE adjustment a week was given. Early in the spring, I began to sit up in an arm chair. The body was straight, as there was no bending at the hip joints. Time passed and I grew better daily. Began to get out of bed one, two, three, then four days a week. Next I began to use crutches and with the aid of someone by my side, would walk around the room, then the house. In July I put away the crutches and resorted to a cane. About the 15th of July, I went outside alone and saw the great outside with all its natural splendor for the first time in FOUR AND ONE-HALF YEARS.

On September 22, 1933, another X-ray was taken at the same laboratory, these X-rays showing the neck region almost totally free from the welded condition which held it fixed so long. The bony growths were broken apart, allowing greater freedom of motion with the exception of two places in the lower spine. The two hip joints were not totally free.

As time passed, I grew better and better daily. I grew stronger; my weight increased; my walking grew better; my pain gradually faded out of the picture; my spine and other joints grew looser. I began to sleep longer as time passed. Now I can sleep as long as ten or eleven hours, can lie either on right or left side. I can turn over in bed for the first time in five years. I now weigh about 135 pounds, a gain of about 60 pounds since I began taking the Hole-in-One adjustments. I can walk for quite some time without the aid of my cane. I can do all my own work. I now turn my head from side to side. The shin bone and toe infections have been healed entirely for over six months. I go outside at any time I please, and walk up four or five stories to the building in which I live, every day. Today I have three to four bowel movements without any artificial aid whatsoever. I go outside every day wearing pajamas, and I

do not feel any cold at all. This is a wonderful change from that of the summer of 1930 and 1931 when it was so hot that people were frying eggs on the sidewalks and I had two hot water bottles, one at my feet and another at my hips, day and night, with several heavy bed coverings over me through the entire summer. I was freezing all the time.

The only thing now left of my complicated illness is a stiffness of my hip joints due to bone deposits not yet dissolved. If it were not for this stiffness, I would be normal in every respect, healthy, and feeling better than I have in TWENTY-FOUR YEARS.

It might be of interest to all who read this to know that I have NOT had an adjustment since June 15, 1933. The Neurocalometer had informed the doctors on the case that there was no necessity of any further adjustments as the causative factor had been returned to its normal position and was no longer producing nerve or spinal cord pressure. My progress has been slow BUT SURE since the last adjustment on June 15, 1933.

Today, after trying every other known method of healing; after being sent home by the world's most noted surgeons to live or die as fate saw best; after spending four and a half days in bed pleading for death; after taking thousands of adjustments over a course of eight years without results, by the OLD method of adjusting; after my spinal bones melted and ran together, and my hip joints welded fast; after my spinal cord sclerosed, giving rise to paralysis; after wasting away from a 150-pound athlete to a 70-pound pile of bones which lingered in the valley of death for four years—TODAY, AFTER ONLY NINETEEN CHIROPRACTIC ADJUSTMENTS ACCORDING TO THE HOLE-IN-ONE METHOD WITH THE AID OF THE NEUROCALOMETER, I AM ENJOYING LIFE AND AM POSITIVE OF ENJOYING BETTER LIFE IN THE NEAR FUTURE.

NINETEEN HOLE-IN-ONE ADJUSTMENTS have done what all other methods of adjustment, by the thousands, have failed to do. Nineteen Hole-in-One adjustments have done what ALL OTHER methods of healing put together COULD NOT DO. Nineteen Hole-in-One adjustments have done what the world's greatest surgeons could not do. Nineteen Hole-in-One adjustments have saved a life that was doomed to die according to all who examined me from time to time previously. Nineteen Hole-in-One adjustments have restored a body that was paralyzed, twisted, wasted, pain wracked, and rotting, to a healthy looking individual free from pain and enjoying life for the first time in ELEVEN years. Nineteen Hole-in-One Chiropractic adjustments have done in one year what all other methods combined could not do in ELEVEN years!

I want it clearly understood that NO OTHER kind of healing method or methods were used in regaining my health. I started out to put the HOLE-IN-ONE to the test. I desired for my own benefit to prove it true or false. It has survived the test AND SO HAVE I.

CHAPTER XIX.

THE NCM MORE IMPORTANT NOW THAN BEFORE!



OUR position on the all-important questions of

WHEN to adjust

WHEN NOT to adjust

WHERE to adjust

WHERE NOT to adjust, is the same now as it has been consistently for the past 10 years.

Before the advent of NCM, we palpated ridges and valleys; hills and dales; and we felt justified in bumping them down or up. Later came the spinograph. Then we thought we could SEE sublaxations because it revealed to our eye the inner irregularities of comparative positions of vertebrae. So we "adjusted" all we thought we saw.

In 1923 came the NCM which taught us WHEN there WAS an interference; WHEN there WAS NO interference; WHERE interference was; WHERE interference WAS NOT. Gradually the evolution of understanding, interpretation, competency in use stepped up our practice. Now we establish the following rules:

1. Adjust only WHEN there is a sublaxation present; meaning thereby pressure and interference.
2. Adjust this only WHEN there is a 2-pt. or more interference heat-reading present.
3. Adjust only WHEN and WHERE this heat-interference-reading is in the superior 3rd cervical vertebral major region, appearing with consistent regularity approximately at the same location.
4. Adjust no other place, at no other time, no matter how many or how large readings may be found at other places.
5. Check with NCM to be certain that you HAVE given an adjustment; HAVE released pressure upon nerves; HAVE restored transmission to mental impulse supply.

The average Chiropractor today, is prone to do what he did yesterday—ignore the most important and essential elements

necessary to be remembered and used to accidentally and occasionally get sick people well.

In days previous to 1923, when spinograph revealed misalignments between any and all vertebrae, there grew in our ranks a "general adjusting, spinal misalignment correction" group; who thought, because there WERE misalignments, they must be bumped or pushed out of the sight of the spinograph or the spinographer's eye. In thus seeing MISALIGNMENTS, not knowing they were NOT subluxations, he began "adjusting" misalignments FOR subluxations; and while he has been occasionally and accidentally doing some good, he has done incalculable harm, notwithstanding he was doing so innocently and with good motive. Even then his cases would have been better off if he had ignored all misalignments revealed by spinograph and confined himself to adjusting a la meric system for the meric system would pick a less number of places than his general-all-over overhauling spinographic method.

The same possible lax and loose error can now again creep into our professional picture; dangerous and much more so than under the former period. Getting this new torqued subluxation and torqued adjustment idea; simple and easily understood as it is; many Chiropractors are going to see the NECESSITY for spinographs, have them taken, analyze them according to this new work now laid down; and because spinograph reveals TWO OF THE FOUR ELEMENTS, they will torque an adjustment at times and places when they should not. Every time such is done, it will increase damage and NOT correct it.

(The "two of the four elements" referred to above, does not mean two of four elements stated above in THIS Chapter, but refers back to first THREE elements as found in Chapter VIII, under heading "A Vertebral Subluxation Must Have Three Directions." Please refer back and clarify that now.)

Example: A Chiropractor will have an A-P and lateral cervical view taken. He will analyze the A-P view, saying: "The head is low on the left, the atlas is low on the left, the axis is low on the left; the spinous process of the axis is right of the median line." He will look at the lateral view and say: "And the spinous process of the axis is inferior; therefore there IS an axis subluxation PRI"; and proceed to "adjust" it WITHOUT KNOWING WHETHER THERE IS OR IS NOT; WHETHER

IT THEN EXISTS OR DOES NOT EXIST; NONE, SOME, OR LITTLE INTERFERENCE IN TRANSMISSION OF MENTAL IMPULSE SUPPLY.

How is ANY Chiropractor TO KNOW THE CORRECT POSITION OF A TORQUE WITHOUT A SPINOGRAPH? Outside of its use, all is guesswork as to position. How is ANY Chiropractor TO KNOW WHEN INTERFERENCE IS OR IS NOT PRESENT WITHOUT AN NCM? The spinograph cannot, does not, and neither do we contend that it can reveal information as to interference. All it reveals is position. The NCM cannot, does not, and neither do we contend that it can reveal information as to position. All it reveals is location of interference and when present or absent. Even though spinographs were taken hourly, they would still reveal only misalignments and possible occlusions; but not prove WHEN OR WHERE INTERFERENCE IS.

Do not interpret films in the light of WHERE interference is, meaning because there is a 4L between atlas and axis, don't read your films concluding that the kink or twist is of a certain vertebra and of a certain direction to correspond. The kinked vertebra may be either atlas or axis (and it IS vitally necessary that YOU KNOW WHICH if you desire to step-up percentages, reduce time, increase staying-put value—which after all means being a BETTER Chiropractor.)

To "adjust" any place, any time, when there is NO pressure or interference to transmission, is to open a field of dangerous practice that would INCREASE OCCLUSION AND INCREASE PRESSURE, THEREBY DECREASING TRANSMISSION AND MAKING EVERY SUCH CASE WORSE. The fact that we have now simplified the location and interpretation of positions of vertebrae in the subluxation area does not release or reduce our responsibility to the case TO KNOW WHEN AND WHERE pressure and interference are or are not present.

This new work requires more exacting use of SPGH, and more careful use of NCM. It remains one of the essential issues that you MUST adjust ONLY when there IS interference; you MUST NOT adjust where there IS NO interference; you MUST KNOW when you have or have not given an adjustment and have NOT increased pressure, raised interference and re-

duced transmission; that the presence of a kink twist of a vertebra as revealed by the Spinograph is not the sole or only guide to follow in giving an adjustment. If it were, you would "adjust" atlas or axis and many other places every day, and be right back to general adjusting, meric system, majors and minors, without added improvement or step-up in efficiency. There is no other way THIS information, as to existence or absence of interference and when present or absent, can be ascertained EXCEPT BY COMPETENT, EFFICIENT, and HONEST USE OF NCM.

The NCM has less AND MORE value now, under this new work, than before. In earlier HIO days, we read cases to determine not only WHERE interferences were but WHEN they were; not only WHERE interferences were not, but WHEN they were not. It was well that BOTH interference aspects were recognized, studied, and applied. Reading WHERE interferences were and were not, proved much that we could not have been in a position to understand and present and know now. If interferences were found located in 10 places and we thot it necessary to adjust 10 places, we would have gone on believing 10 places were necessary to be adjusted. Gradually, by ascertaining WHERE interferences were and observing that upon adjusting ONE place we checked out nine, we learned that ONE PLACE was A SPECIFIC adjustment for the other nine locations. In earlier HIO days, the location of WHERE interferences were helped determine character of spinograph interpretation we made of spinographs of positions of vertebral subluxations. In earlier HIO days, we determined that NCM interference reading was between atlas and axis. We read spinograph with the objective of studying positions of vertebrae, between atlas and axis, to see what to do to separate those intervertebral foramina to release that pressure AT THAT PLACE. Today a case may have one or more superior cervical readings, at one or more superior cervical places, and it matters not WHERE, so long as it is present WHEN adjustment is to be given. Today we determine position of torqued subluxation independent of location of NCM interference reading.

WHERE interference is has LESS locating value than before. Regardless of WHERE NCM interference reading is, spinographs

will be read as herein taught and adjustment given according to torque interpretation of A-P and lateral spinographs. But, while WHERE NCM reading is takes on LESS significance today than before, WHEN to give an adjustment and WHEN NOT TO, takes on GREATER value than before. The more SPECIFIC and exacting we get our information, the greater value of getting case WELL if done right. The more specific and exacting we get information, the greater potential possibilities for doing damage case can receive, if done wrong.

Discussing this condition of withdrawal of importance of WHERE NCM readings were, one chiropractor said: "Now, I'm going home, going to spinograph all cases, read them according to this new work, and adjust them accordingly. In this way I will try your HIO idea and see if it works." I asked him HOW and by use OF WHAT MEANS he would know WHEN to adjust. He said spinographs would reveal whether there was or was not a torqued subluxation present; and which one and its direction. I admitted he was right as far as that conclusion went, but WHEN could or would he know WHEN an interference was or was not present, for upon that fact depended whether he did or did not adjust today; how often he should adjust; determined the days or weeks it should be left alone; that without THIS VITAL DETERMINING ELEMENT he could not use my HIO SPECIFIC adjustment method. He little realized he would condemn this method if it didn't work with 50% of its substance absent.

A few investigators who refer back to meric system days, frequently ask questions bearing upon relative values of meric system vs. HIO, on cases. Much can be said FOR the former meric system; more can NOW be said against it. The HIO system of today, even tho confining its adjustment to ONE vertebra, adjusted at ONE place, and adjusted only ONE way, without change from day to day or month to month, secures the greatest, most efficient and quickest results for acute or chronic cases, and reverses acute or chronic cases quicker than any other method in our history of vertebral subluxations and their correction with attendant restorations—but the inverse is also true: done wrong, the HIO system of today, confining its adjustment to ONE vertebra, adjusted at ONE place and adjusted only ONE way, without

change from day to day or month to month, attains the worst, least efficient, and is the quicker to create acute or chronic conditions than any other method in our history of vertebral subluxations and their production with attendant interferences—both ways proving that it IS THE SPECIFIC in the causative as well as corrective sides of dis-ease or health. The HIO not only IS the subluxation method of correcting THE cause of dis-ease thus RELEASING THE specific pressure, but, if done wrong, it creates pressure and interferes with transmission more positively and certainly than before. The element of over-adjusting or adjusting wrong direction, wrong vertebrae, wrong times, becomes an important element to be seriously avoided.

The HIO, done right, is much safer for public health than meric system done right. The meric system, done right, is safer for public health than is HIO done wrong. The meric system, done wrong, is safer for public health than is HIO done wrong. Meric system, done right, is better for public health than is HIO done wrong. BUT HIO, done right, is better than meric system done right. The percentage of potential possibilities is greater for good or bad with HIO than is dormant in meric system, done right or wrong.

Hypothecating that an average of 1 out of 10 NCM readings made, an adjustment might be given. 1 out of 10 you do; 9 out of 10 you don't. NCM readings are NECESSARY to determine WHEN one out of 10 IS NECESSARY and WHEN 9 out of 10 ARE NOT NECESSARY.

If you adjust once when it IS necessary you do the right thing, at right place, at right time. Only good can accrue. If you "adjust" nine times when UNnecessary, you do wrong things, at wrong places, at wrong times and pile up injury nine times more as against the possible once when it WAS needed. 90% of the time harm has been produced. It is MORE important to know when NOT to do. It is equally AS important to know WHEN to do the ONCE needed.

In a former Chapter we discussed possible good as well as harm that can be done by remote control injection of a foreign source of concussion of force. If force is applied at wrong places, wrong times, a wrong has been done because of impossibility of human body to absorb it for bodily good. More especially is this

dangerous when applied to superior cervical region without knowing which one, which way, and the evaluation of degrees of direction as outlined fully in another Chapter of this book under Tailor Making the Adjustment. Under side-slip adjustments it is obvious how subluxation could be increased in direction, increasing interference and do untold damage.

The NCM will give information of break-reading heat-interferences as to location of cord pressure, as determined by heat-readings upon fibres under pressure IN THE CORD as they branch off from and proceed to emit between intervertebral foramina, the same as you can read extensions of some of these fibres below as they emit from inferior intervertebral foramina. The SPGH gives detailed pictorial proof of kink, twist, wrench, or torque itself and its exact location. Information gained by BOTH methods puts you in a position to give a CORRECT adjustment upon THE vertebra subluxated to release pressure and permit restoration of normal quantity flow of mental impulse supply to all the body and relieve brain congestion above and cure organic or functional dis-ease below.

If a Chiropractor, without exact knowledge of what his NCM or SPGH reveals, thinks he can understand any or all these elements without instruments to lead him aright; and proceeds to punch at the neck at any place, in any way, or at any time he pleases, he is as liable to do as much damage as he could do right if he were right. To blunder at this work is dangerous because he can either create a torque where none existed, or he can increase an already existing one. To get sick people WELL, it is not sufficient to punch backs, push bones, or crack vertebrae—that old order is gone.

To give an adjustment "WITH THAT EXTRA SOMETHING" means to be able to UNTORQUE THE TORQUED SUBLUXATION at a time when it IS a subluxation, not at a time when it is not a subluxation; where there IS an interference present and not where it is absent. If this is done, it will have "staying put value."

CHAPTER XX.

“UNCANNY” OR EFFICIENT?



HANDS do what mind directs. As mind directs, hands do. Hands can do no more than mind conceives. That establishes the difference between an artist and a laborer. Both may use paints—one colors a barn, the other puts brains on canvas, via hands. One has developed his creative mentality, which directs his hands; the other has a mind undeveloped that moves his hands. It is that difference in mental creative development that steps any person out of ordinary ranks and puts him into higher brackets of efficiency, accuracy, and competency in work. If a Chiropractor had never seen a vertebra, his mind could not conceive an adjustment. If a “chiropractor” has never studied a vertebral column, his hands will push bones. If a “chiropractor” has never studied Chiropractic, his mind will think and his hands will do what he conceives, viz., mixing. The greater the concept of the Chiropractic principle and practice, the more extensive the understanding of a vertebra, vertebrae, relationships of vertebrae, movements of vertebrae upon each other, special and differing relationships of special vertebrae with correspondents, all these give to mind a keenness of understanding, the building of mental pictures, the clarifying process that builds the artist, which makes more possible a more correct adjustment.

It is common knowledge, generally conceded, frequently stated and agreed, that “there is something uncanny about B.J.’s adjustment—something none of the rest of us can get or have gotten. He seems to look right thru you and see the sublaxation. He can feel and know. He gives an adjustment with an uncanny accuracy of repositioning it and staying put,” etc. I deny that premise. There is nothing I have which you can’t get if you go after it as I did. Thomas Edison was considered “inspired.” He resented that inference. He defined “inspiration” as 98% perspiration. It IS true—there IS something uncanny about my adjustment. That uncanniness was trained in by long hard hours. That uncanniness consists of thousands of hours of seeing, looking at, studying, palpating thousands of vertebral

osteological specimens, both pathological, traumatic, and anomalous, in the finest osteological collection in the world, collected for that specific purpose—a collection owned by The P.S.C.; many years devoted to an exclusive study of Chiropractic philosophy, science and art; much time exclusively devoted to an understanding of the human body; its organs; function, normal and abnormal; palpation and developing a mental picture via fingers; reading of hundreds of thousands of spinographs to know the spinal column; its segments, as is, in living beings; study of subluxations as revealed and their adjustments—all these and more has developed a keen and comprehensive mental concept of one thing, applied one way, to accomplish one objective; all of which places one man above and beyond the ordinary, common and usual. The majority of people call this “uncanny”, but it ceases to be that when you know its past and how it gradually grew. So keen NOW is that mental picture that I have frequently taken five vertebral columns, mixed the 130 vertebrae of the five columns in one box, in one mixed group. Blind-folded, I picked them out, one by one, sorted them, arranged them, and put those five spinal columns together without one mistake, by the sense of touch. This “uncanniness” has been trained in, after years of building a keen mental conception of vertebrae.

A few years ago, I exposed a trance medium. There had been a standing challenge of \$10,000 between the late Erich Weiss (Houdini) and any medium whose arts he could not duplicate by trickery, thus proving fraud. One by one they fell before him, except the one I exposed. Houdini was so pleased, he closed his show in Cleveland and jumped to Davenport to find how she had baffled him and I exposed her. Sitting in my home, after the exposure had been told in detail, Houdini took out a spool of thread, pulled off several yards, dropped it by his feet. He removed his feet out of his shoes. His socks were always cut away at toes. He took his toes, tied hundreds of knots into the thread WITH HIS TOES. When he had the thread completely filled with knots; he, as deliberately, untied them all WITH HIS TOES. In this way Houdini used wasted time to develop his sense of touch with toes, developed wasted time to an advantage. He wanted THOSE TOES highly developed for he was often called upon to perform, by trickery, what many mediums did

under guise of spirit control. This was ONE of the reasons why Houdini was THE MASTER of arts for which he was never equalled.

When I have a vertebral dislocation for adjustment—which is rare, thank goodness — I take spinographs and study them by the hour. It does not take AN HOUR to read the specific nature of that dislocation, but it takes not less than 2 hours of intense concentration upon those spinographs to burn that picture into my mind. There is to come ONE SPLIT SECOND when I am going to give an adjustment upon which life will hinge, either way. At that ONE SPLIT SECOND, I will have NO TIME to think about what I WOULD LIKE TO DO. THAT must be thot in advance, thoroly and completely; finished action must be completed mentally before the first physical move is made. I will have NO TIME then to prepare, to get ready, to commence, to begin thinking about what I would like to do. THAT must be thot in advance so that it IS a fixed thot for action. When the adjustment IS given—that is when the arms move, the brain was set by several hours of advance thinking. Friends call this advance preparation “uncanny” insight. If there be “uncanniness” about my knowledge or ability in adjustments, it is brot about by years of thousands of hours of burning a mental understanding of work to be done, media upon which it is to be done. It may seem foolish to suggest carrying vertebrae in your pocket and feeling them from time to time, but every feel is a thot; every thot is an idea; every idea is a movement in embryo, every movement in advance embryo is a correct “uncanny” adjustment some day.

I can conceive of no more valuable item constantly at hand than a catgut-strung, human spinal column; or, in its absence, at least an occiput, atlas and axis, as pocket pieces. At the left of my desk is the original spinal column, the first purchased by my Father. It has been picked up, looked at, studied, thousands of times. In my grip are an occiput, atlas and axis. Idle moments can be valuable moments. Waiting in a car? Take out the occiput, atlas and axis and palpate one or the other; it develops sense of touch, and clarifies the mental picture. It is this “extra development” that takes ordinaries out of the “also ran” and builds champions of first rank.

We have presented new light on the question; have caused the area to be confined to a specific location, with a specific condition to be sought and seen, requiring specific adjustment to reverse it. With the reason given, we have moved upward one more important step in the correct establishment of a greater knowledge of AN EXACT SPECIFIC FOR THE CAUSE OF ALL DIS-EASE.

For the first time in 20 years of spinographic research studying hundreds of thousands of plates and films, we have laid down a certain definite, specific, positive MECHANICAL CONDITION OF A MECHANICAL SUBLUXATION at a place where certain mechanical motions can and do occur which do not occur any other place in similar manner. Mechanically the atlas and axis are more vulnerable in characteristic motions than any other vertebra in the spinal column. In the past we have looked over 24 vertebrae for "subluxations," never knowing exactly what, where, or how. Gradually we reduced it to majors, which consisted of a few of the 24. Now we know there definitely exists, in every sick person, a kink, twist, wrench, or torqued vertebra which will be found in the superior cervical vertebrae.

FOR THE FIRST TIME YOU HAVE

- A DEFINITE MECHANICAL CONDITION TO SEE
- AT A DEFINITE MECHANICAL PLACE TO LOOK FOR IT
- KNOWING IT WILL BE DEFINITELY MECHANICALLY EXISTING
- WHICH DOES NOT DUPLICATE ITSELF ANYWHERE ELSE IN A SPINAL COLUMN
- WHICH LATERAL AND A-P SPINOGRAPHS WILL DEFINITELY REVEAL
- WHICH CAN BE DEFINITELY ADJUSTED, MECHANICALLY
- WHICH WILL DEFINITELY RELEASE A MECHANICAL MULTIPLICITY OF PRESSURES
- WHICH WILL DEFINITELY AND MECHANICALLY STAY PUT IF CORRECTLY REVERSED IN DIRECTION IN THE ADJUSTMENT PROCESS
- WHICH WILL SPINOGRAPHICALLY PROVE DEFINITE CORRECTION

—AFTER WHICH ALL MISALIGNMENTS BELOW WILL
AS DEFINITELY AND MECHANICALLY FADE
OUT OF THE SPINAL COLUMN WITHOUT FUR-
THER ADO ABOUT OR UPON THEM DIRECTLY.

This idea of a three-directional subluxation of atlas or axis is not new; neither is the idea of torqueing an adjustment of either. But the subject as now confined in its all-inclusive and all-exclusive features IS new, therefore is so revolutionary that it is hardly expected that science at large or any profession (including Chiropractic) is going to adopt it without applications sufficient to test it. The worth of the work herein presented steps outside of the realm of any one profession. It is so worthy that it does not belong to any one group. It is now so practical that it belongs to humanity direct, more especially the sick to whom it of right belongs.

I suggest that members of the Chiropractic profession:

- (a) use NCM competently to locate WHERE and WHEN there is a superior cervical major interference in atlas and axis region
- (b) expose and interpret accurately, according to information herein laid down, an A-P and lateral cervical spinograph to secure accurate knowledge of which vertebra IS THE torqued subluxation.
- (c) give torque adjustment correctly as to direction and efficiently as to delivery that it may be untorqued
- (d) try all, exclusively, on a group of cases on which all methods, including previous HIO efforts have failed. Take a group of 20 to 30 cases, covering observation of 30 to 60 days, which will suffice to convince the most skeptical, stubborn, and prejudiced practitioner and/or patient;
- (e) bearing in mind that any beginner in the use of any of these scientific arts mentioned, needs instruction, practice, and experience to develop his scientific ability to establish a higher service than would be noticeable at first.

If a Chiropractor is sufficiently efficient, competent, accurate, and honest with his facts to:

1. Locate the exact place and time of interference with the NCM.

2. Take A-P and lateral spinographs correctly of the torqued vertebrae,
 3. Ascertain, without error, by process of exclusive analysis, the vertebra that creates the torque
 4. And can give an adjustment that untorques the torque
- he then will be able to get sick people well. If he can't do all four exactly right, he will fail in exact ratio as some of the elements are either forgotten, neglected, or inefficiently, incompetently, inaccurately, or dishonestly done.

CHAPTER XXI

A MIRACLE HAPPENED DURING PRE-LYCEUM CLINIC REVIEW COURSE



ONCE we were satisfied to think we could THINK where a subluxation was; and believed that wherever we thought it was, that was it.

Once we were satisfied to palpate up and down the ridges and bumps, hills and valleys, and believe that whatever we felt out of line, that was a subluxation.

Once we were satisfied to believe that every such vertebra was a "subluxation."

Once we were satisfied to believe that every push, shove, bump, and crack we gave that the patient felt or we heard "pop" was an adjustment.

Then we became dissatisfied.

We began to demand TO KNOW whether what we thought was so; whether ridges and bumps, hills and valleys, and everything out of line WAS a subluxation; whether every one such needed to be pushed, shoved, bumped, and cracked, felt or pop; and whether such WAS an adjustment.

The SPGH and NCM entered.

It proved that many things we palpated, which we thought were subluxations were not such in fact; they were not present when we thought they were; we were pushing many places that should have been left alone.

Naturally, this split our family into the groups that still thought they knew from those who knew they didn't. I had facts; they had theories. No two groups AGREED. DIS-AGREEMENT was the order of the day.

Because of a variance in understanding of what constituted what a vertebral subluxation was, there was a variance in interpreting what a spinograph revealed; because of a variance in interpreting what a spinograph revealed, there was a variance in listing of a vertebral subluxation; because of a variance in listing of a vertebral subluxation, there was a variance in proper adjustment; because of a variance in proper adjustment

there was a variance in results; because of a variance in results, no two Chiropractors could agree on the most vital section of Chiropractic, viz., the art. Now that there IS a simple understanding of elements, interpreting, listing, adjustment, and results, all Chiropractors can and should agree on ALL elements that make for results.

A MIRACLE HAS NOW HAPPENED.

For the first time in 38 years of Chiropractic a group of 200 chiropractors gathered, studied new work at Pre-Lyceum, 1933, saw what they saw AND AGREED.

They AGREED, not once but many times.

They AGREED, not on one idea but many.

They AGREED, not on one case but many.

They AGREED, not on one subluxation but many.

They AGREED, not on reading one spinograph, but on many.

They AGREED, not on listing one subluxation, but on many.

They AGREED, on how to adjust one vertebra.

They AGREED, not on many majors to adjust, but THE correct one.

Actually and in reality this motley group of believers and disbelievers; those who came to scoff and those who came to learn—200 from the four corners—were able TO AGREE, day after day, case after case.

HOW did this miracle come to pass? Why has it not existed before? How did it exist now? What made this possible after 38 years?

SCIENCE!

SIMPLIFIED SCIENCE!

SIMPLIFIED SCIENTIFIC FACTS!

THE ELIMINATION OF THEORY, DOUBT, AND GUESS!

THE FINAL ESTABLISHMENT OF CHIROPRACTIC ON A DEFINITE, POSITIVE, EFFICIENT, ACCURATE, COMPETENT AND HONEST SCIENTIFIC SPECIFIC BASIS.

Chiropractic has NOW been builded where ALL Chiropractors can take same case, find same interference; take spinographs, and read subluxations the same; ascertain correct adjustment

exactly alike, and uniformly get each case well with same adjustment.

1933 PSC-NCM-SPGH-HIO SCIENCE HAS MADE THIS MIRACLE POSSIBLE IN CHIROPRACTIC.

Five years from now, at the rate of growth we are now making, THIS WORK will be the exclusive standard, professionally and legally.

CHAPTER XXII

AXIS PLI, TRUE, SUBLUXATIONS



BETWEEN Illustrations 66 and 272 inclusive, we selected as varied a list of cases from border line to extremes we could after culling thousands of spinographs. We studied ALL as tho they WERE listed under classifications listed. We ask our readers to bear in mind that SOME listed under respective headings classified should be listed under other classifications. Example: IF axis was THE subluxeation, then films here list it as such. They have been studied AS an axis when it might more properly be listed as an atlas wedge-side-slip. To build up evaluations in degrees, we placed them here. If the student, seeing these pictures, sees an atlas wedge-side-slip listed as an axis, we ask him to bear with this seeming incorrectness to build up possibilities of this heading. If the student sees a set of films listed as axis PRI true, and he decides it IS an atlas right high wedge-side-slip, we shall have no quarrel, for more than likely we agree.

The following views are divided into sets, each covering one particular direction of a characteristic kind of subluxeation of axis. The purpose of each set, each consisting of an A-P and its mate, a Lateral, is to enlarge upon how we can have many axis subluxeations, each of the same general direction, in which each set will differ oftentimes very much in degrees of the subluxeation with their differing evaluations to be placed upon the differing three directions of which each subluxeation consists.

We have listed several different and varied directions of the same general (PLI, true) kind of subluxeation. In addition to those listed here, we refer you back to the sample typical type of this kind of subluxeation as found in Illustrations 66, 67 and 68. When studying varied values of three directions of Axis PLI, true, here, also add to that list the Axis PLI, true, Illustrations 66, 67, 68, etc., found in preceding pages.

In previous pages we have listed one typical sample of each characteristic axis or atlas subluxeation. We have arranged them there in the following order:

Axis PLI, true
PRI, true

PLI, false
PRI, false
PI
Atlas AIR
AIL
ASR
ASL

The following groups will be arranged in the same order.

In previous pages, where we listed one typical sample of each axis subluxation, we listed the A-P views first, and then laterals. That plan is followed in subsequent pages as regards axis subluxations. In previous pages, where we listed one typical sample of each atlas subluxation, we listed lateral views first, and then A-P's. That same rule will be followed in subsequent pages as regards atlas subluxations.

Refer back to Illustrations 66, 67 and 68, and add them to the following collection.

Illustrations 66 and 67.

Head is low on right (A-P view).

Atlas and axis low on right.

Spinous process to left of median line.

Spinous process inferior to normal position to approximate degree of the usual.

It would be listed PLI. The degree of each direction is slightly more than some, but not as bad as many others; therefore listing as stated.

Comparison of degrees of direction PL and I, with others in this group, proves them not as bad as many.

Illustrations 183 and 184.

Head is lower on right than usual (A-P view).

Atlas and axis correspond.

Spinous process is to left of median line.

Lateral view shows axis spinous process considerably more inferior than spinous process is to left.

The main degree of subluxation here is an inferior spinous process; more so than is head, atlas, or axis low on right or left of median line.

All three directions are to be adjusted, but more from inferior of spinous process than other two.

Illustrations 185 and 186.

Head is low on right, but not unusually so for a PLI true subluxation.

Atlas and axis are low on right to correspond (A-P view).

Spinous process is to left of median line, therefore follows rule.

Lateral view shows axis spinous process even more inferior than was spinous process of Illustration No. 184.

Spinous processes of axis, 3rd, and 4th cervical vertebrae are crowding each other.

Axis spinous process is VERY much inferior.

The major direction of subluxation here is an inferior spinous process. This direction, for correction, is far more important than is raising the head, atlas, and axis on right side; altho all must be done.

The subluxation in Illustrations 185 and 186 would be listed as 183 and 184, except MORE from inferior on adjustment, in this group, than even with 80 and 81.

Illustrations 187 and 188.

Head is more low on left in this set than any previous (A-P view).

Naturally, atlas and axis would also be more low on left.

Spinous process follows rule of being to right of median line.

Note compensatory left cervical curve to correspond.

Lateral view shows an apparent lordosis. Where there appears a compensatory lordotic curve, it usually appears in the same locality, viz., upper cervical between occiput and sometimes including 3rd cervical. This curve shows plainly in Illustration No. 186 also.

Lateral view shows torque between atlas and axis with spinous process of axis inferior upon 3rd cervical.

Altho we have stressed, in other places in this book, question of abnormal subluxated position of odontoid process of axis, we here again call your attention to where it is located in these PLI true subluxation series.

Listing on this subluxation would be low head plus; L plus, and I plus.

Illustrations 189 and 190.

Head is low on right (A-P view).

Atlas and axis are low on right, all three being about as much as in Illustrations 82 and 83, 84 and 85.

Spinous process follows rule of being to left of median line.

A-P view also shows slight compensatory curve to left of cervical region.

Lateral view shows marked, and almost angular, lordotic curve to correspond.

This is brot about by marked inferiority of spinous process of axis, jamming spinous processes immediately below and separating centra on anterior.

Lateral view plainly exhibits torque between axis and 3rd cervical.

Listing would be PLI; plus on L and double plus on I. By getting UNDER spinous process of axis and adjusting it VERY much superior AND anterior, odontoid process will be directed into its normal position in fovea dentalis, thereby relieving compression of spinous processes; equalizing spaces on centra on anterior.

Illustrations 191 and 192.

Head is VERY much inferior on right (A-P view).

Atlas is VERY much inferior on right, but not quite as much as is occiput.

Axis is not quite as inferior on right, as is atlas.

Spinous process is left of median line.

Note slight left compensatory curve of superior cervical region; more so than inferior region.

Lateral view shows an almost straight, perpendicular cervical region. Compare this with previous lateral views, notwithstanding all were PLI true axis subluxations. It vividly portrays a marked difference between subluxations of same classifications and general directions.

General listing would be PLI, true. Specific adjustment would be to raise head on right, plus; from L, plus. Lateral view shows some inferiority, but not nearly as much as in former views; therefore I would be about usual.

Illustrations 193 and 194.

Head is low on right (A-P view).

Atlas and axis are low on right.

Spinous process is to left of median line, thus following usual rule.

Left compensatory cervical curve is observable clearly in this picture.

Lateral view shows rear of head is inferior. Inferiority of axis spinous process draws atlas backward and downward and thus pulls head back with it. This rear and inferior head position is seen in majority of all axis subluxations, true or false. However, now and then it does not appear.

Spinous process of axis is inferior, crowding upon 3rd cervical.

Adjustment for this subluxation, as portrayed in this set, would be more to raise head, atlas, and axis on right and to correct spinous process of axis more from left to right than it would be to adjust it from inferior to superior.

Compare this spinous process inferiority with others preceding and you will note it is not as far inferior as others.

Listing would be P plus, L plus, and I.

Illustrations 195 and 196.

Suppose, for the moment, we read these two films differently than we have done with all others so far.

Hold them before you. Obviously, head, atlas, and axis are low on right. Glance to lateral view. Note that spinous process of axis is not badly inferior; it is not crowding spinous process of 3rd cervical. Notwithstanding head, atlas, and axis are VERY much low on right, and axis spinous process is not much inferior, odontoid is very much posterior into neural canal, just the same.

Head (lateral view) is not much inferior on posterior. Still it is an axis PLI true, but of an entirely different degree than some others we have had.

Adjustment would be to raise head, atlas, and axis VERY MUCH on right; laterality from left to right on spinous process would be VERY MUCH from inferior left to superior right, with a moderate degree of superiority from inferiority on axis.

The comparisons, so far, illustrate what is meant by tailor-

making your adjustment to fit each kind of different subluxation, as no two ARE alike.

Illustrations 197 and 198.

Head, atlas, and axis are low on right (A-P view).

Spinous process of axis is to left of median line.

Lateral view shows a cervical region almost perpendicular in its straight lines.

In this respect, it follows similarity of Illustration No. 192 which had a lateral view about the same.

Lateral view shows axis spinous process slightly crowding down into spinous of 3rd; but not to any great extent.

If you study both views, side by side, you become impressed that the definite correction needed is to raise head, atlas, and axis on right, more than to raise spinous process of axis from inferior to superior, even tho latter is somewhat necessary.

A-P view shows left lateral compensatory curve.

And, while the matter is constantly before us, it behooves us to study location of odontoid process and to remember that THAT is the objective of all correction in axes adjusting. Note where odontoid process is in lateral view.

Illustrations 199 and 200.

A hasty, or even a studied understanding of this A-P view would lead one to conclude that we have a fracture or dislocation in cervical region; yet this is an exaggerated type of axis PLI true subluxation. Left cervical compensatory curve is VERY much marked in this case.

Adjustment, as observed necessary by A-P view, would consist of raising head, atlas, and axis superior on right; adjusting axis spinous process from left to right, in a torqued ARS direction.

Lateral view shows head driven backward upon right shoulder; cervical vertebrae all jammed or crowded together on rear, and all very much separated on anterior of their centra.

EACH of THREE directions in these two views would need VERY MUCH on opposite direction.

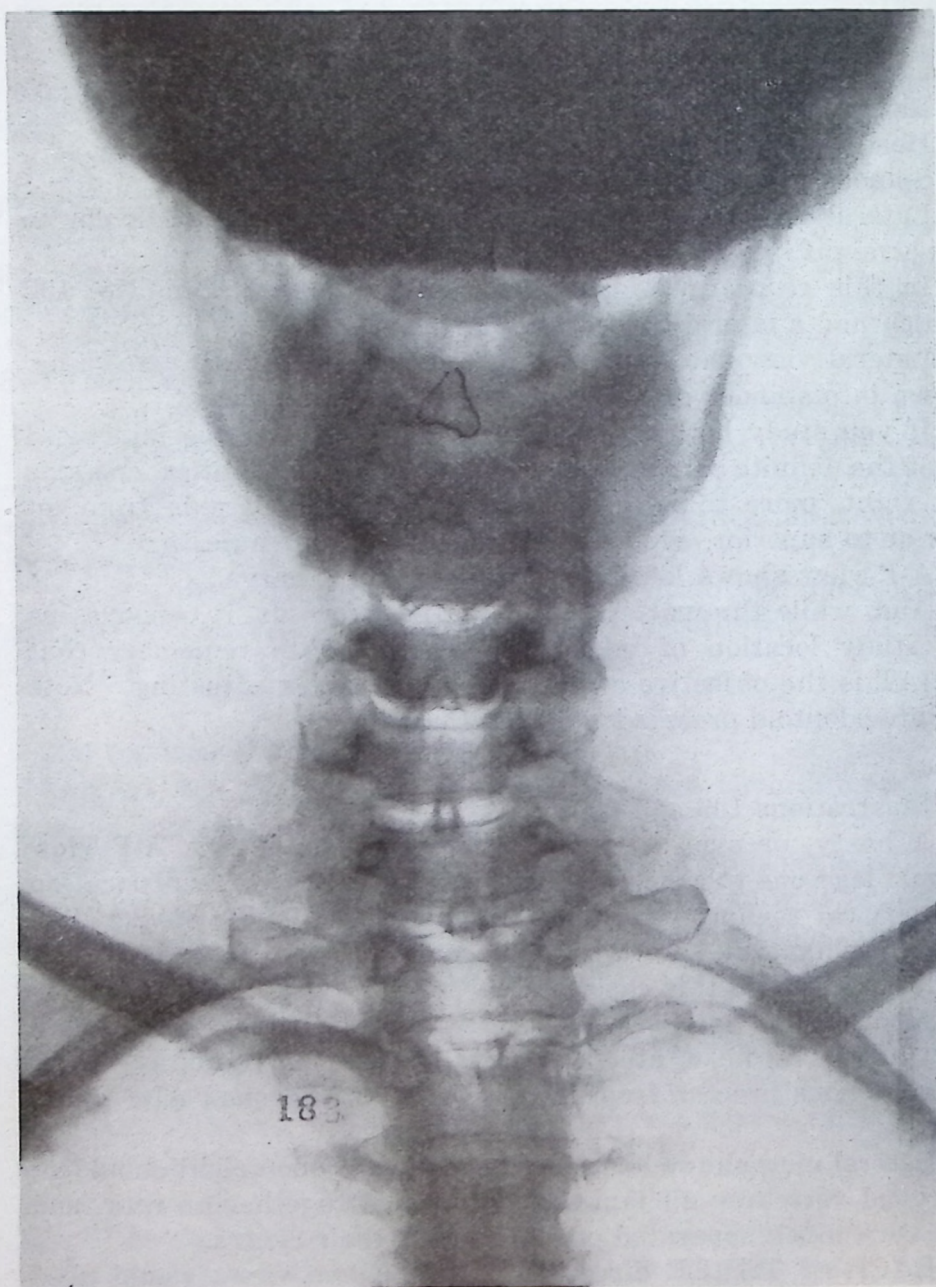


Illustration No. 183

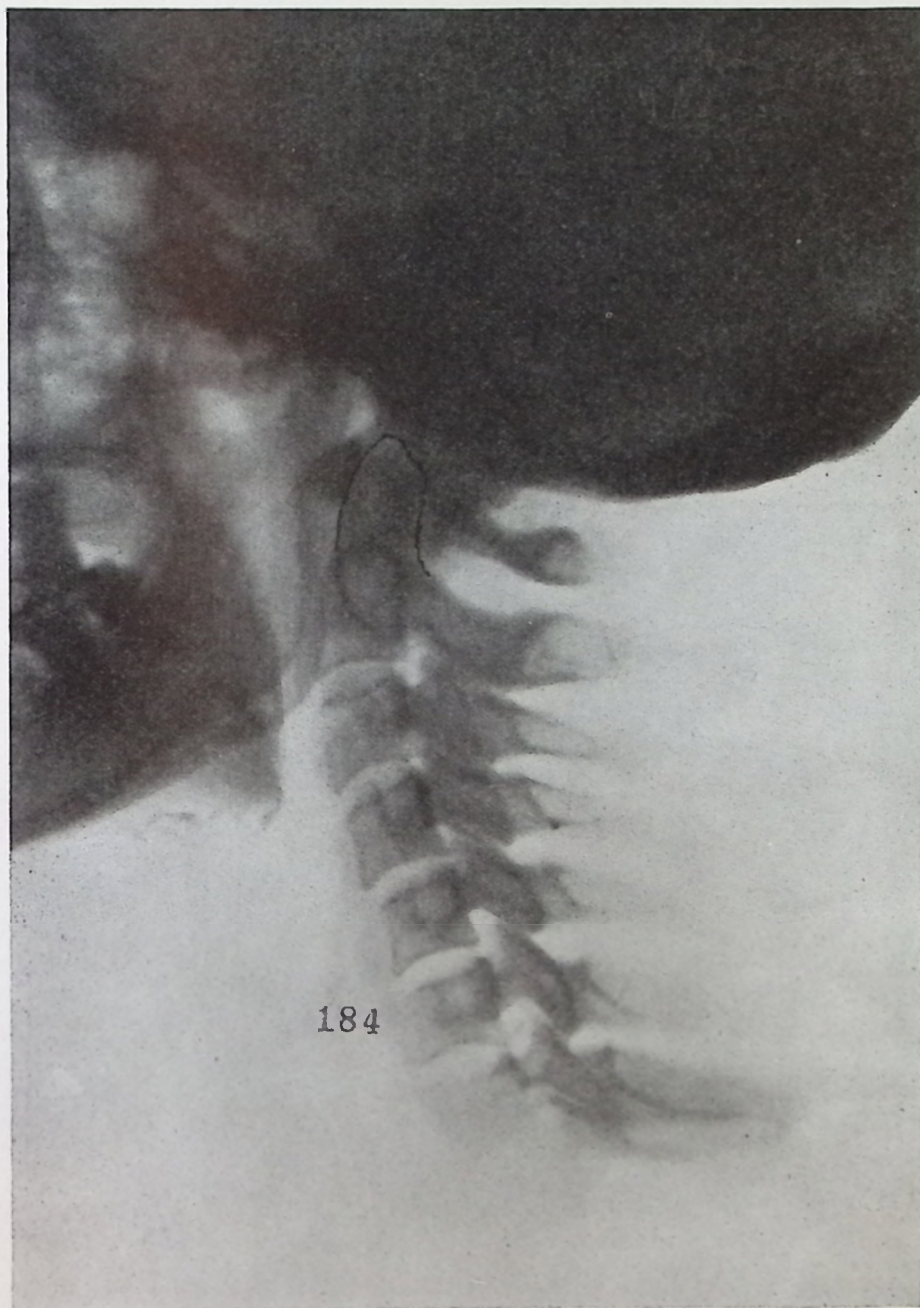


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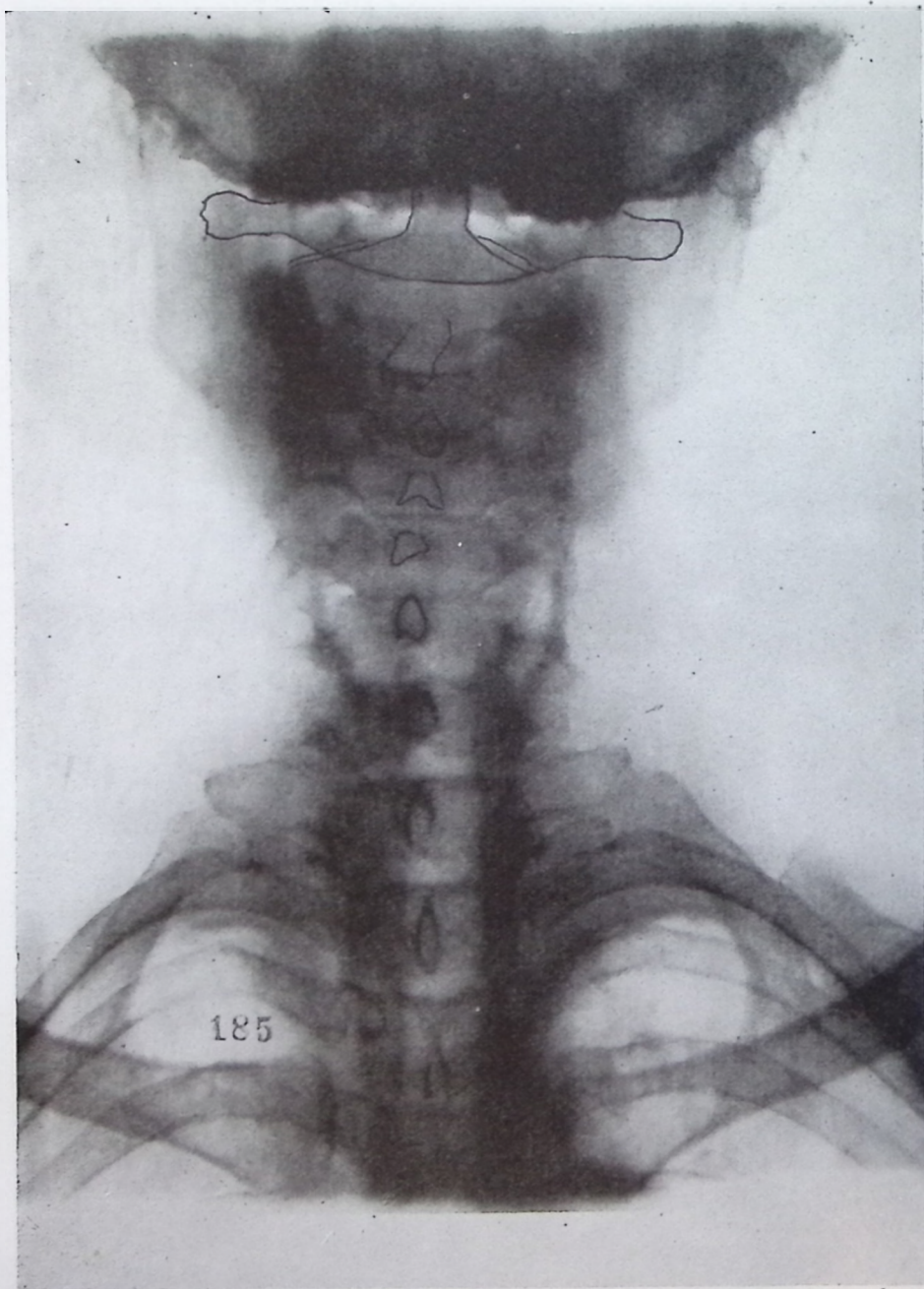


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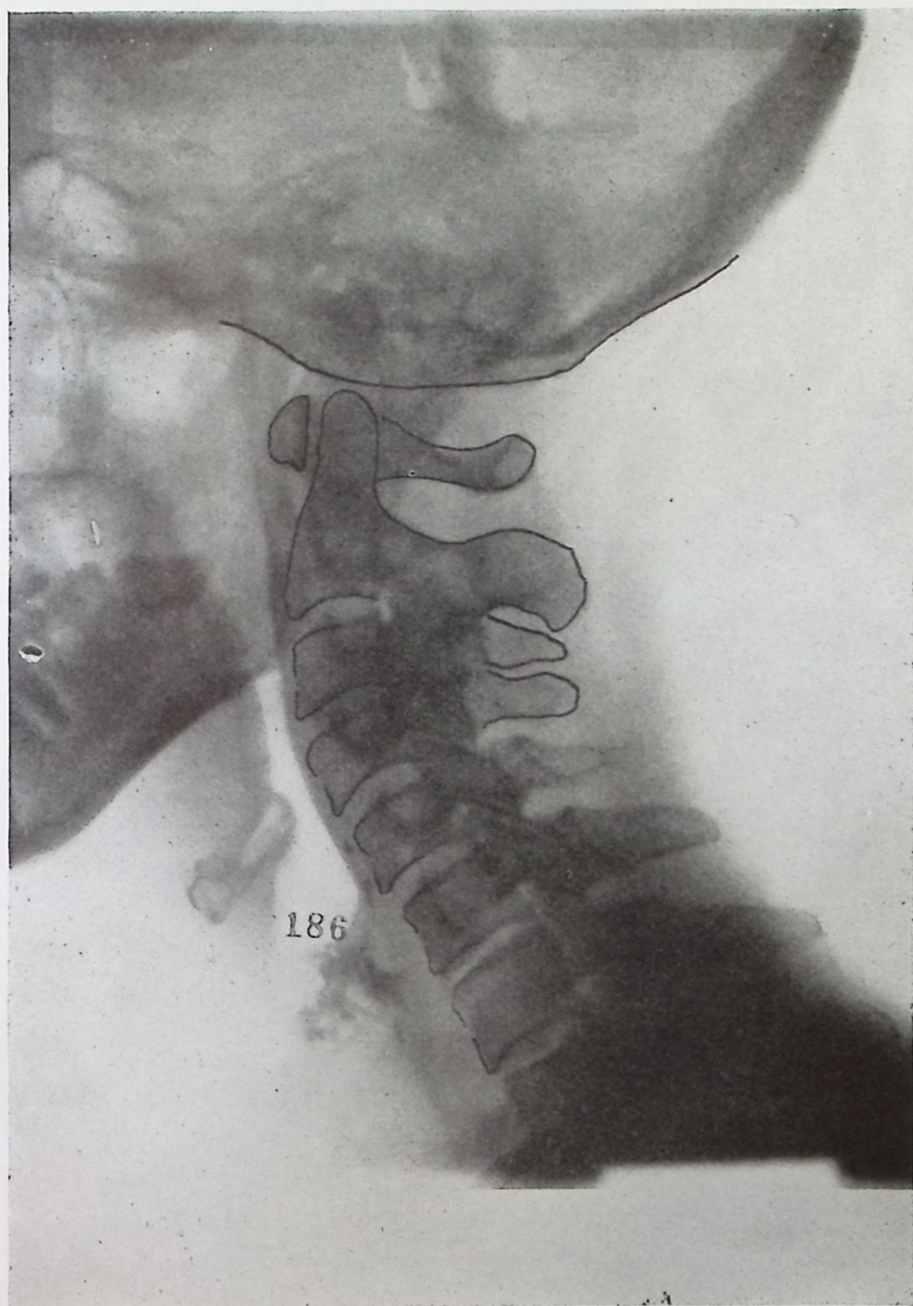


Illustration No. 186



Illustration No. 187



Illustration No. 188

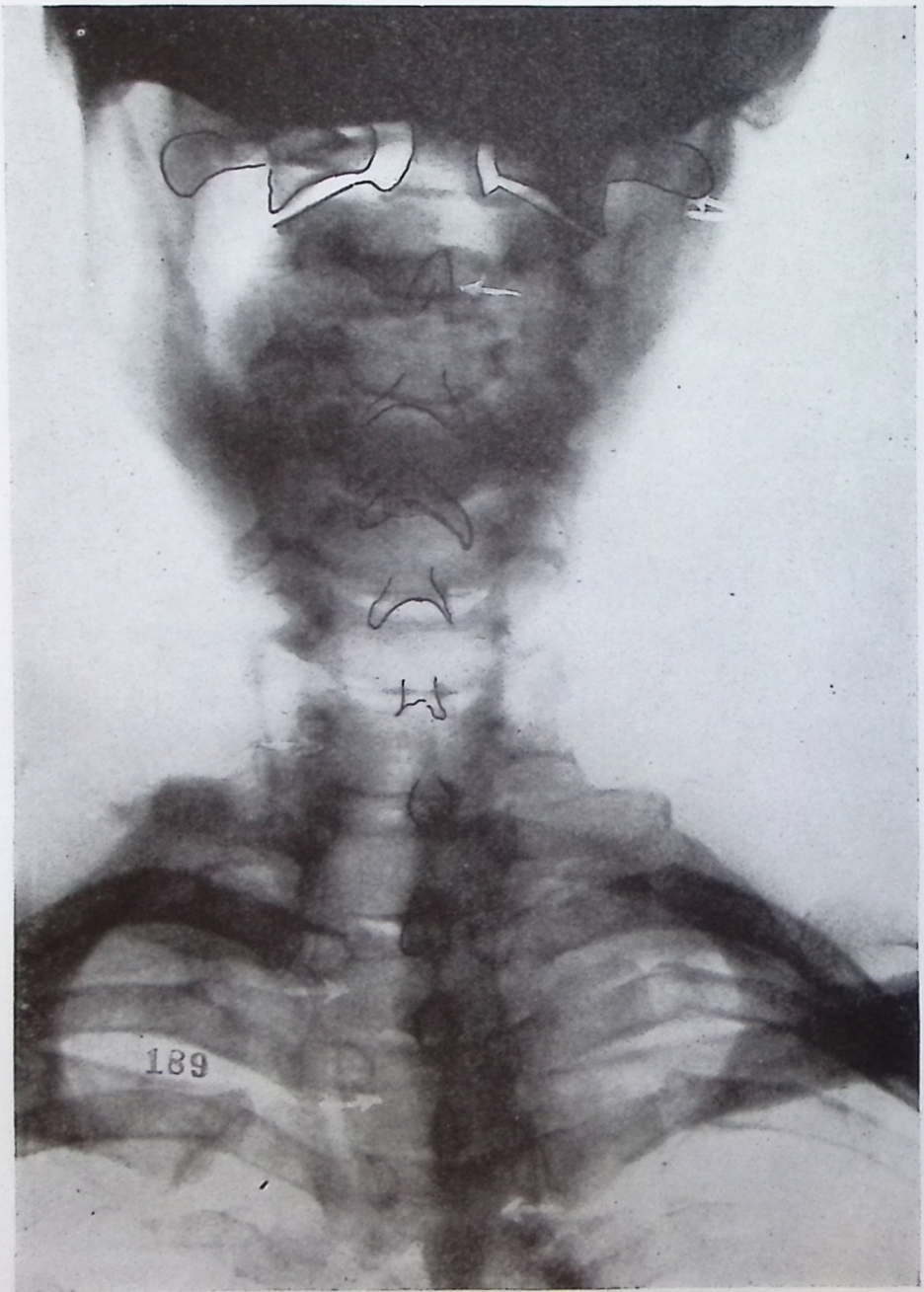


Illustration No. 189



Illustration No. 190

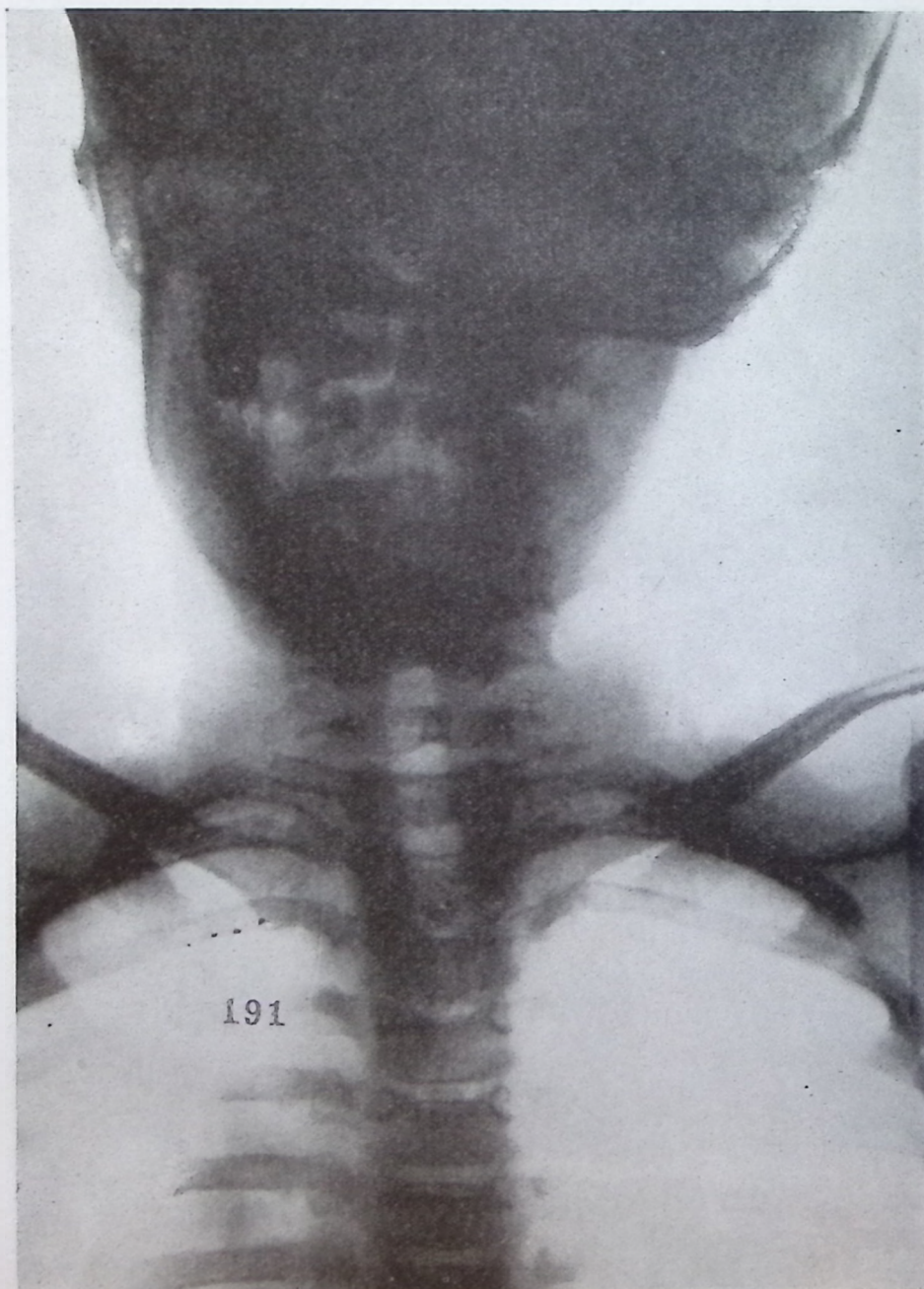


Illustration No. 191



Illustration No. 192

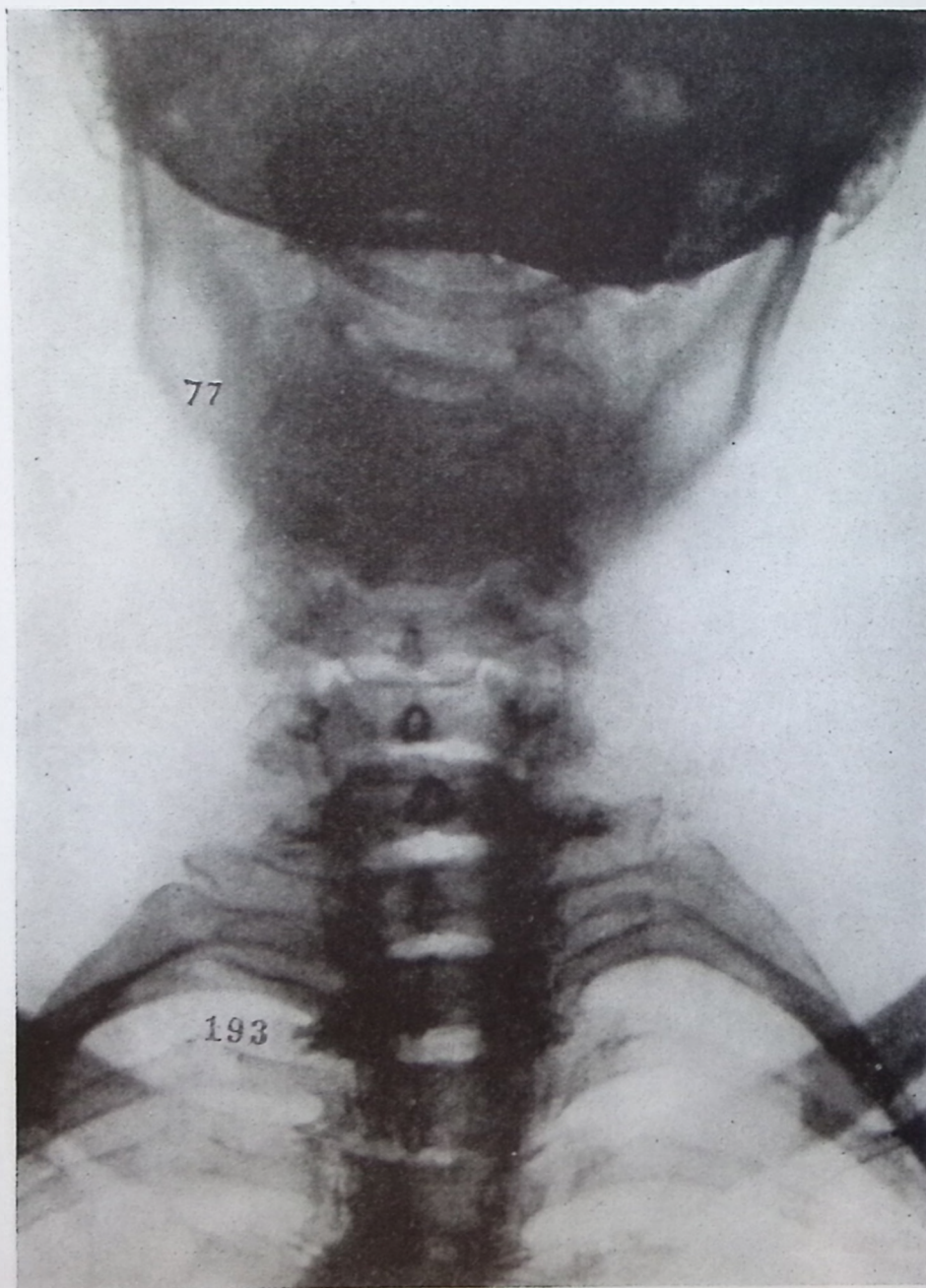


Illustration No. 193



Illustration No. 194

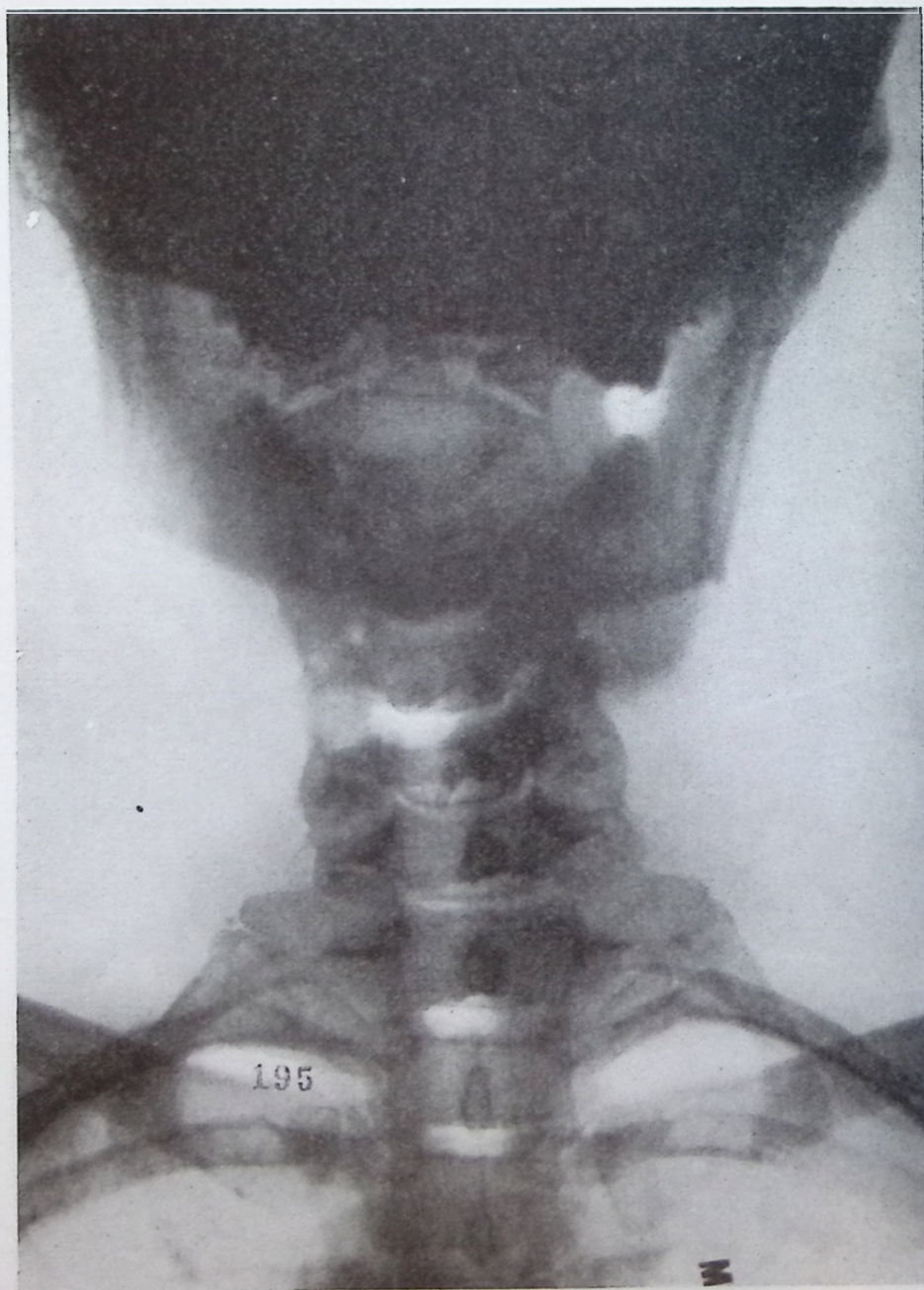


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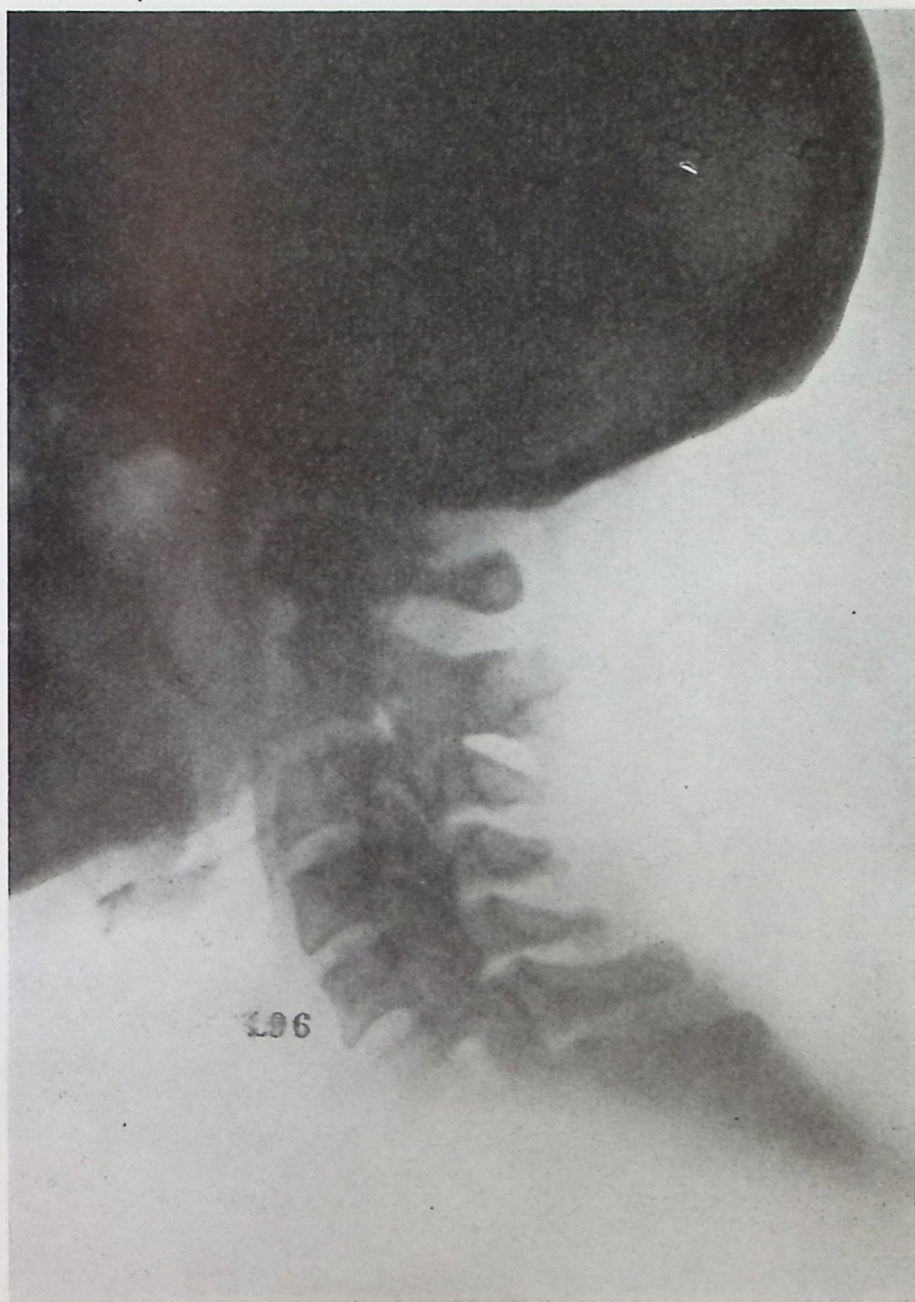


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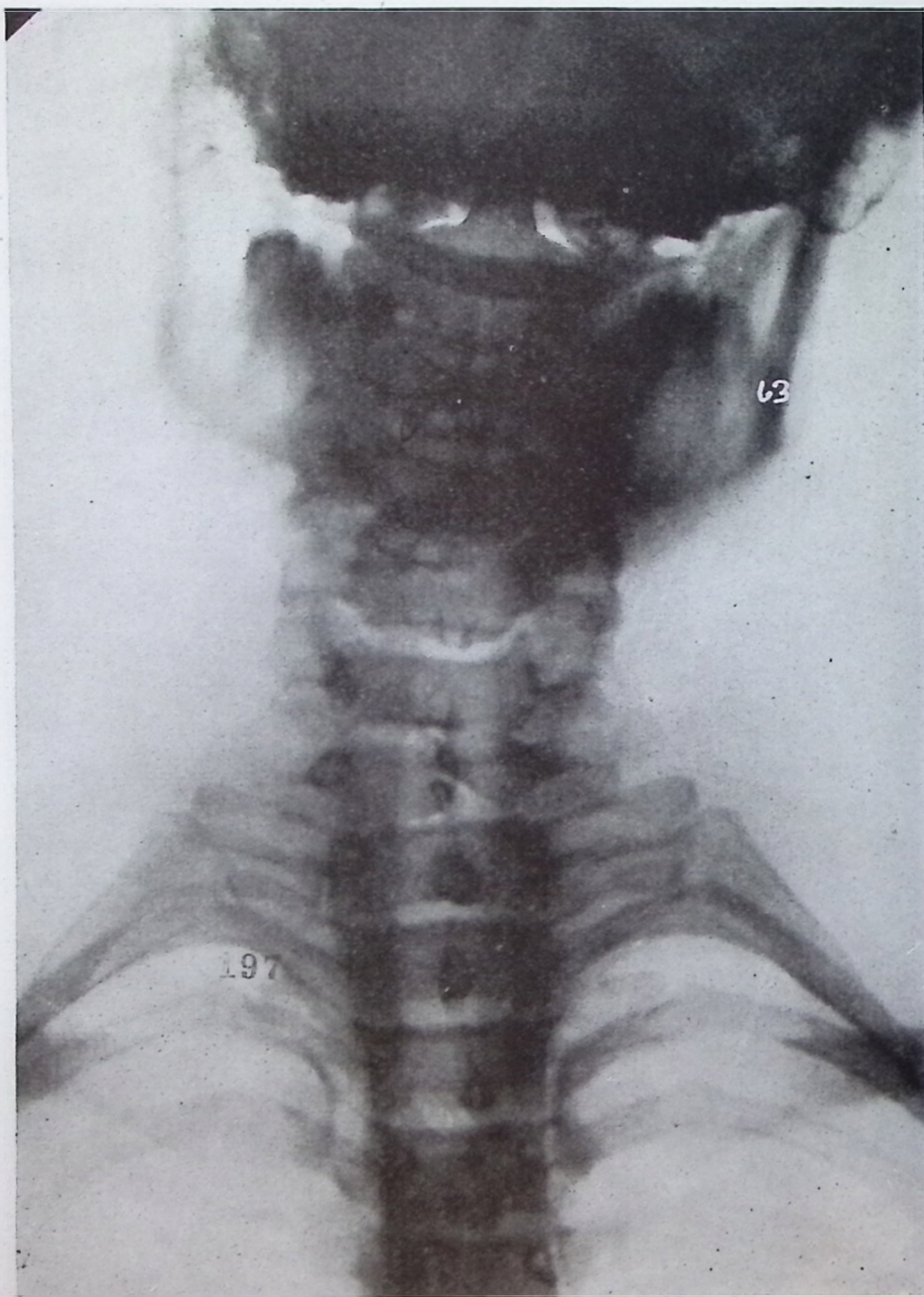


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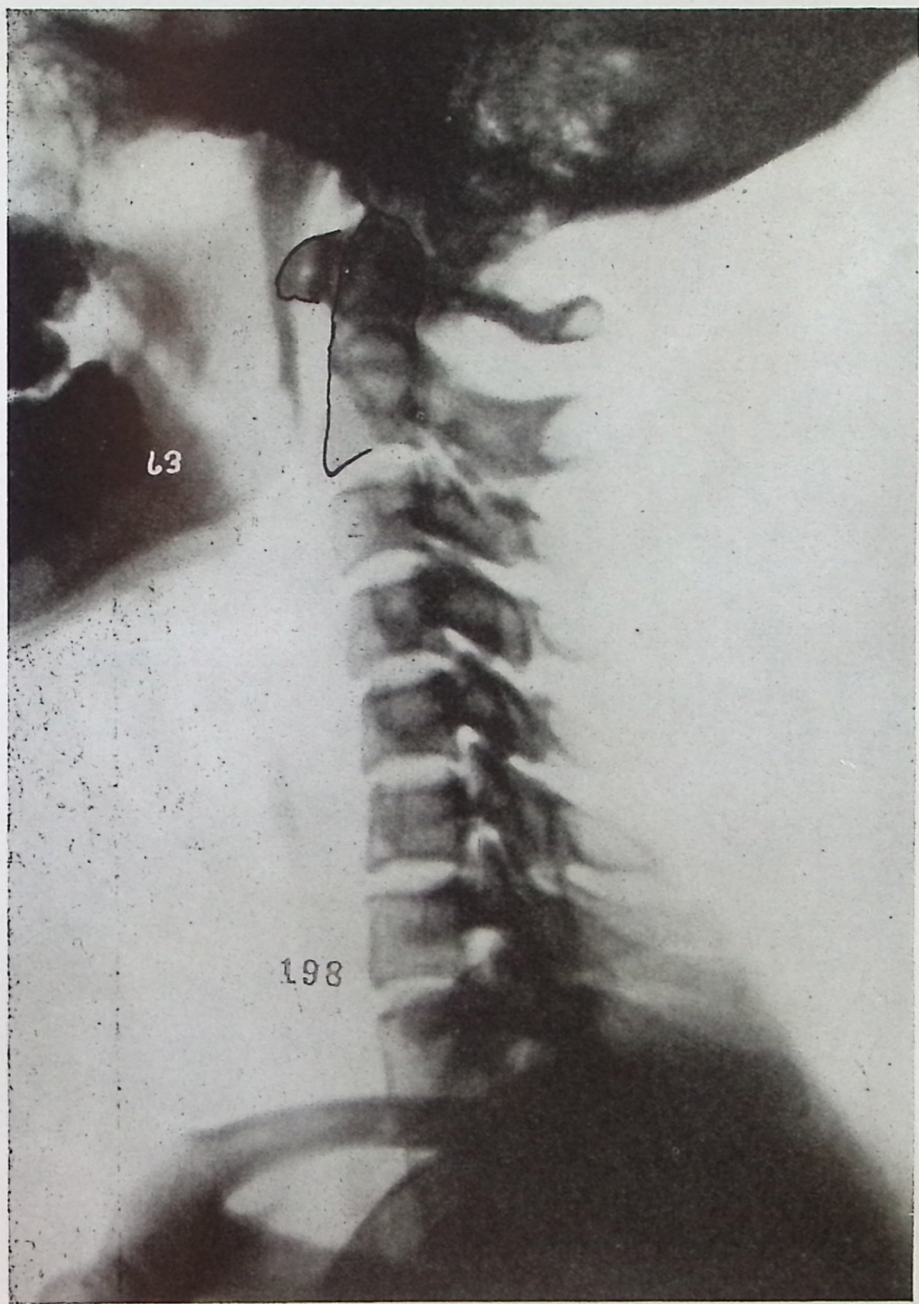


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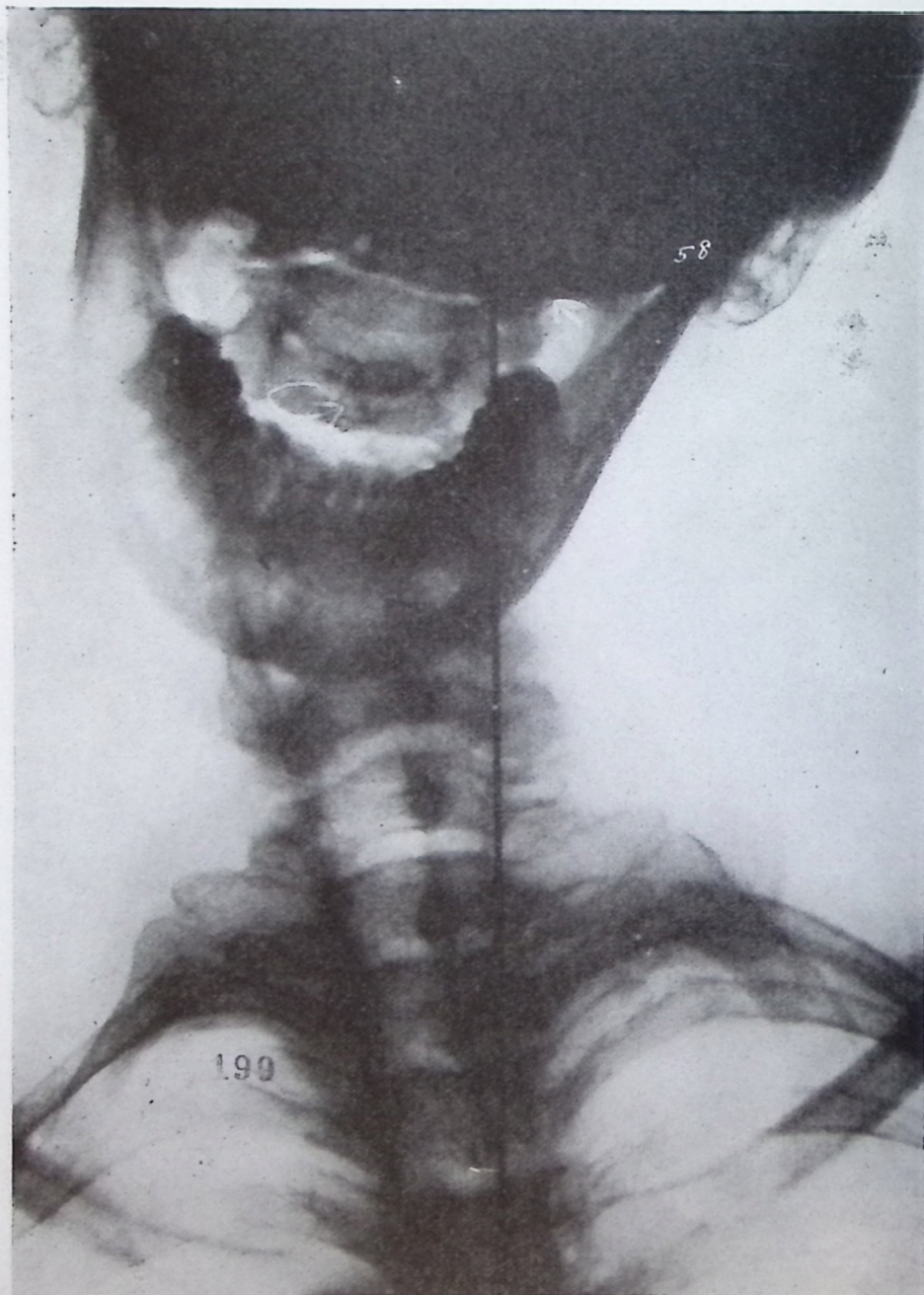


Illustration No. 199



Illustration No. 200

CHAPTER XXIII

AXIS PRI, TRUE SUBLUXATIONS



IEWS in this chapter will confine themselves to true axis PRI subluxations. They will vary, just as have true axis PLI. In studying varying degrees of subluxations, all of same direction, add to this list the schematic drawing, Illustration No. 69, and spinographs Nos. 70 and 71.

In Illustrations 70 and 71, head is low on left
atlas is low on left
axis is low on left
axis spinous process is to right of
median line, and is crowding on to
spinous process of third.

The listing of that subluxation, as to evaluation of degree, would be P plus, R plus, and I, inasmuch as raising head, atlas, and axis superior on left and adjusting from right to left, on laterality, is more important than is raising spinous process from inferior to superior, because first two directions are worse, in proportion, than is latter.

Illustrations 201 and 202.

It might be well now to glance back over A-P's on axis true PLI subluxation pictures, and note general trend to a left compensatory curve of cervical region. With that general picture in your mind, now glance over A-P views of this set of axis true PRI subluxation pictures, and you note general trend to a RIGHT compensatory curve of cervical region. These curves are adaptive to torque subluxation. They are not traumatic within themselves; neither are they pathological. To adjust torque subluxation by untorquing its abnormal position, is to automatically correct apparent false curve by normal adaptation.

Head is low on left (See A-P view).

Atlas and axis are low on left.

Spinous process of axis is right of median line; therefore follows rule.

Cervical adaptative curve is to right.

Lateral view presents rare abnormality—8 cervical vertebrae. What appears to be a transitional second atlas has an odontoid process on its superior base.

Spinous process of typical axis is located on 3rd cervical.

Extra vertebra is a transitional atlas-axis located between atlas proper and axis proper without odontoid. This makes no difference to the torque subluxation, either in existence, location, or adjustment.

Lateral view shows greatest crowding between spinous process of third vertebra and fourth. Posterior of head is very much inferior, crowding upon 1st vertebra.

Listing would be, raise head, atlas, and axis, superior double plus; adjust right spinous process to left, double plus; and usual I to S.

Illustrations 203 and 204.

Head is low on left (See A-P view).

Atlas and axis low on left.

Spinous process to right of median line, with right adaptative cervical curve.

Comparison with Illustration 201 will suggest that Illustration 203 is not as low or as lateral as was 201. And yet, a comparison on lateral views, between Illustrations 202 and 204, you will note spinous process of 204 is far more inferior and is crowding 3rd cervical spinous process much more.

Both views (laterals 202 and 204) are of true, axis PRI subluxations; they are entirely of different evaluations as to necessity of more inferiority-superiority in 204 than in 202, showing that you cannot hand-me-down adjustments off a common shelf where all are alike.

Posterior or rear of head in 204 shows it markedly inferior, yet not crowding down upon atlas as was true in 202.

General listing would be axis true PRI, but we would list it as: Raise head, atlas, and axis, superior double plus.

Adjust right spinous process to left, double plus.

Superior on spinous process of axis, plus.

Illustrations 205 and 206.

Head is low on left (See A-P view).

Atlas and axis low on left.

Spinous process to right of median line, with slight right adaptative curve but not as noticeable in this as in previous cases.

Degree of inferiority of head and laterality of axis is about same in this illustration as in several previous cases.

Greatest difference between this lateral and previous laterals, altho all of same general axis true PRI types of subluxations, is: head is NOT inferior on posterior. Lateral view does show a more marked inferiority of spinous process of axis than was noticeable in several previous laterals of PRI true subluxations. Take a moment and compare this inferiority of spinous process with others in this series. 204 was the most inferior, previous to this, in this series. 206 is more inferior than was 204.

Adjustment for 205-206 would be of about equal parts; as much superior on left for head, atlas, and axis, as we would to left from right spinous process, and with equal amount from inferior under axis spinous process to superior; torqueing it to ALS—anterior, left, and superior. Keeping the idea fresh in our minds, note lateral where odontoid process is into neural canal. Adjustment is always given to see that IT is corrected back into fovea centralis dentalis.

Illustrations 207 and 208.

Head is low on left (A-P view).

Atlas and axis low on left.

Spinous process of axis is right of median line.

Lateral view shows a very inferior spinous process of axis, crowding upon 3rd, and 3rd upon 4th.

The question frequently arises, "Do we have same kind of subluxations in youth as in adults?" This set of views is of a child about 9 or 10. The rule applies same to youth as to adult. This subluxation, in this child, of an Axis true PRI now exists. It can and will be adjusted. And, it will disappear out of picture; but if this child ever has another future concussion of forces, sufficiently violent to create another subluxation, it will be an axis true PRI. "Once a Major, Always a Major."

Adjustment in this case would be of about equal parts, all three needing plenty of all three directions to correct a marked mis-direction of all three directions.

Illustrations 209 and 210.

Actual spinographs which comprise those in this book, have been gathered from the four corners of the U.S. Cases exposed were those of various Chiropractors so located. Some were taken in PSC Spinograph Laboratories. The purpose of this explanation is to suggest universality of rules herein laid down. There is no such thing as a Davenport subluxation that differs from those of other cities, states, or countries. Adjustment applicable at Davenport is good anywhere in the world. If a principle is sound, then practice should follow suit. If principle and practice are sound, it knows no geography.

Head is low on left (A-P view).

Atlas and axis low on left.

Spinous process is to right of median line.

Right adaptative cervical scoliosis is quite marked.

It has been an observation in study of torqued work, that adaptative studies are interesting if not sometimes important to know. By "adaptative studies" is clearly intended to mean NOT pathological studies with which these cases may be suffering. The average Chiropractor stands ready, quick, and eager to jump at some such statement of mine and desires much to pervert it to meaning something foreign to what I do.

Position of head, regardless of subluxation, is ALWAYS an "adaptative" study. If cervical region is a left scoliosis in an axis true PLI subluxation; or a right scoliosis in an axis true PRI subluxation, then those curves are "adaptative" studies and are interesting side-checks on majors. I am NOT interested in headaches, tooth-aches, toe-aches, etc.

As an "adaptative study," note lateral in this set; see that marked lordotic cervical curve. Not only have we a right cervical scoliosis (A-P view) but we also have a MARKED lordotic cervical curve (lateral view). These observations will NOT change torqued subluxation, in character or in adjustment. It is still an axis true PRI.

(I use the terms "scoliosis," "lordotic cervical curve," etc., with an apology. The curve is not normal, it is adaptative, it is not pathological, it is not a true scoliosis, etc. Yet, some word must be used.)

Description of adjustment, if listed, would be: P plus, R plus, I double plus. If I were describing it, I would say there should

be especial attention paid to increasing superiority of spinous process more than in directing right spinous process to left or raising of axis, atlas, or head on left.

Yes, nail point No. 1 CAN BE placed UNDER spinous process of axis even in this lordotic curve.

There is always a certain drop in quality from the human neck to a spinograph film; from a spinograph film to a photographic print; from a photographic print to a half-tone cut; from a half-tone cut to a picture on printed page. Therefore, I have taken the liberty of sometimes, on some pictures, slightly retouching in some of the salient features; but I have studiously avoided doing any more than was necessary, preferring to leave them as nearly natural as possible.

Illustrations 211 and 212.

Head is low on left (A-P view).

Atlas and axis low on left.

Axis spinous process is to right of median line.

Lateral view shows spinous process inferior, but not nearly so marked as in majority of previous lateral views in this set of PRI true subluxations.

This lateral view brings forth an additional "adaptative" feature different than any we have had so far, viz., posterior of head IS SUPERIOR, throwing head forward rather than usual backward. This lateral also shows one of those perpendicular or straight cervical conditions.

Possibly many of you are thinking that head was "forced" into this position for purpose of taking spinograph that way. This is not true. You can "force" any torque into or out of a picture in modifying limits only by "forcing" head and cervical region to assume some definite "forced" position.

This listing would be P plus, R plus, and I. Head, atlas, and axis are more low on left; and spinous process of axis is more right than is spinous process of axis inferior. So majority of direction of adjustment would be directed to raising head, atlas, and axis and to directing the spinous process to left.

Illustrations 213 and 214.

A-P view shows little tipping of head, atlas, or axis low on left; some laterality of spinous process to right, but not much.

Lateral view shows a decided kink twist between 3rd cervical and axis; a marked separation between axis and 3rd on anterior centra; a crowding of spinous process of axis and 3rd; with a decided inferior head on posterior.

Here is a case where A-P view, while showing some distortion, is not nearly as marked as majority we have had so far; but Lateral view DOES show a marked inferiority of axis. All this proves that we CANNOT rely upon ONE spinograph view alone. Some Chiropractors are prone to take only A-P OR lateral. Both are necessary, as THIS case proves.

Again calling attention to position of odontoid process on lateral view.

Illustrations 215 and 216.

There is a general marked similarity between 215-216 and 213-214. A-P views of both show a general likeness, so far as heads, atlases, and axes being low on left are concerned. Spinous processes of axes, in both, are about to same degree.

Lateral views portray a common likeness so far as position of inferior spinous processes of axes are concerned. However, there is this difference: in 214, head was much more superior and there was more of a separation between occiput and atlas; and atlas and axis, than exists in 216. Here occiput is close down upon atlas, and atlas is close down upon axis. Notwithstanding THIS difference, axis true PRI remains same, and adjustment would be of about same quantity of directions as for 213-214.

Illustrations 217 and 218.

A-P view follows the usual rule.

Lateral view does not show any marked inferiority of spinous process of axis. It is inferior.

We call your attention to marked separation between odontoid and fovea dentalis and V-shaped nature of that space showing separation more at apex than at base of odontoid.

Adjustment would be to ALS, with no marked accentuation in any one direction more than another.

Illustrations 219 and 220.

Again we have spinographs of a youth showing that there is no difference in character, kind, location, and possible variances of degrees of subluxations in youth than those of adults. Neither would there be any difference in character, kind, location, and possible variances of degrees of adjustments to correspond.

A-P view is slightly more inferior of head, atlas, and axis, on left, than is usual or existed in 217. It follows usual rule.

Lateral view shows a head approximately level, with an atlas approximately level with occiput; axis is VERY much inferior, crowding and jamming down upon several cervical vertebrae below.

Adjustment would be to raise head, atlas, and axis on left; to direct spinous process from right of median line TO median line; but also to EMPHASIZE to get UNDER spinous process OF AXIS and raise it VERY much to superior to throw that odontoid process OUT of neural canal into its normal juxtaposition with its fovea dentalis. Inferiority of spinous process of axis should be stressed more than other two directions.

Illustrations 221 and 222.

Head, atlas, and axis are more nearly in alignment in this A-P view than in some preceding groups, altho it does follow rule.

Same is true with spinous process being to right of median line.

Lateral view shows decided kink, twist, wrench, or torque between axis and 3rd cervical, with spinous process of axis crowding down upon 3rd, with a separation on anterior of centra.

Adjustment would accentuate superior direction upon axis spinous process from inferior, or in UNDER spinous process with nail point No. 1.

Illustrations 223 and 224.

Usual rule holds good as regards position of head, atlas, and axis on A-P view. One slightly different adaptative feature here (which proves that every rule has its exceptions) is that cervical curve is to left in lower cervical. This is because of a decided right kink between axis and 3rd cervical. Careful study of this A-P view will show it.

Lateral view is slightly different from usual rule also, in that

cervical is almost perpendicular. I am more convinced as my study of this subject goes on, that anatomies have over-exaggerated the normal anterior cervical curve; that, while it should not be STRAIGHT up and down as this picture portrays, it should be somewhere about half-way between THIS view and usual view portrayed in normal anatomy.

Notwithstanding peculiar and unusual features on both of these views, axis spinous process is still inferior and crowding down on 3rd cervical, forcing odontoid backward into neural canal.

Adjustment would accentuate adjusting spinous process to right and superior. Head is not very low on left.

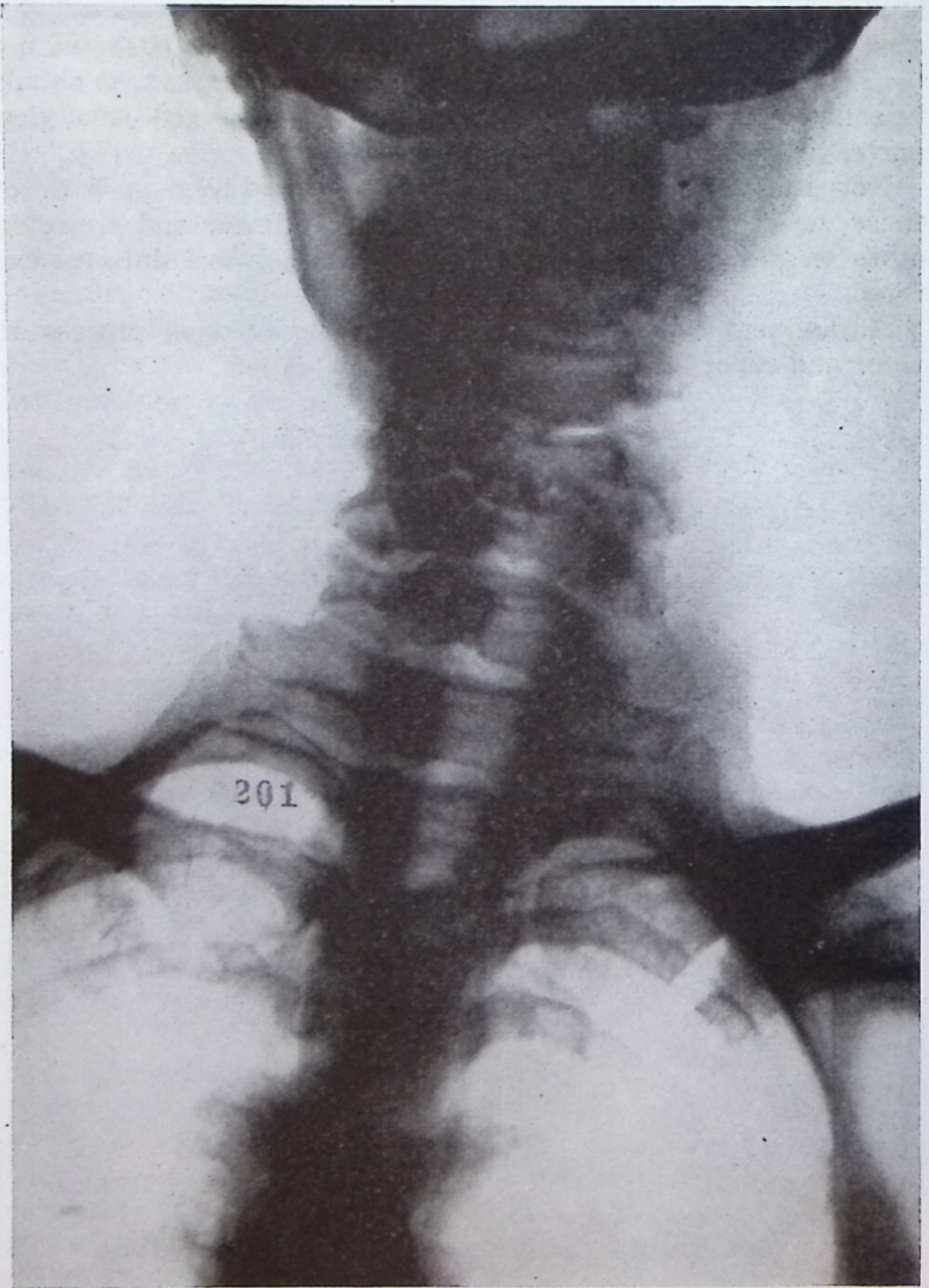


Illustration No. 201



Illustration No. 202



Illustration No. 203

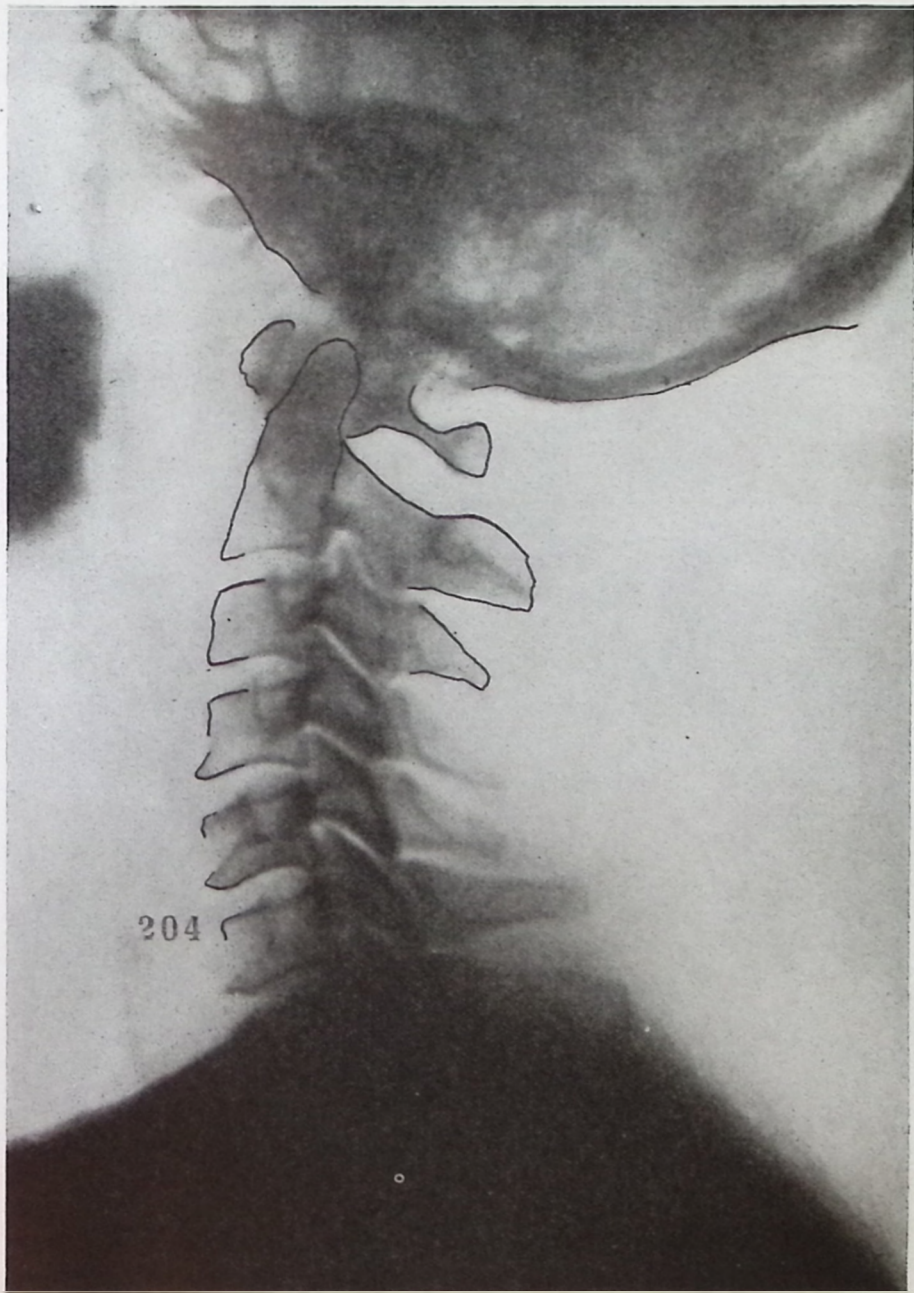


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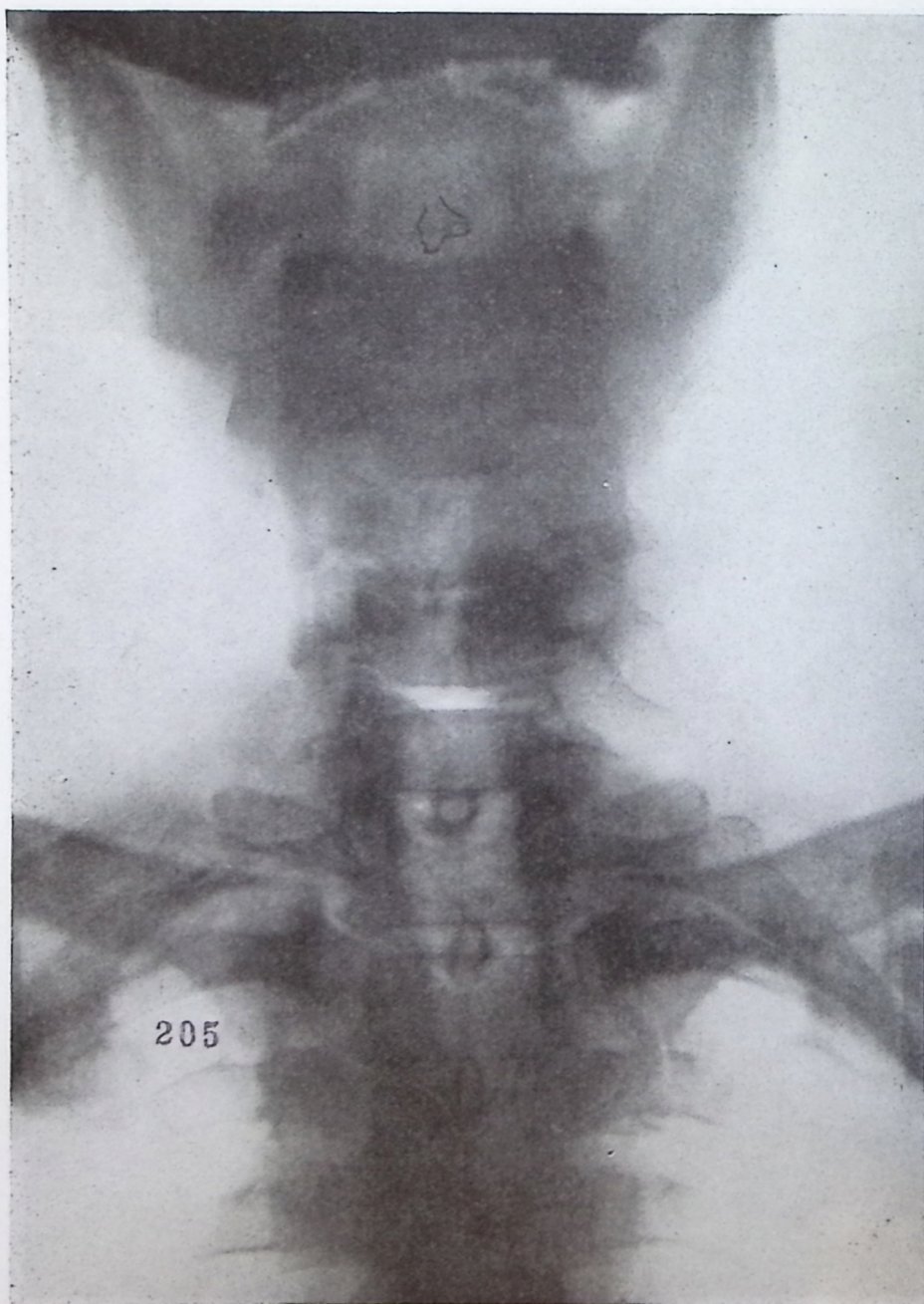


Illustration No. 205



Illustration No. 206

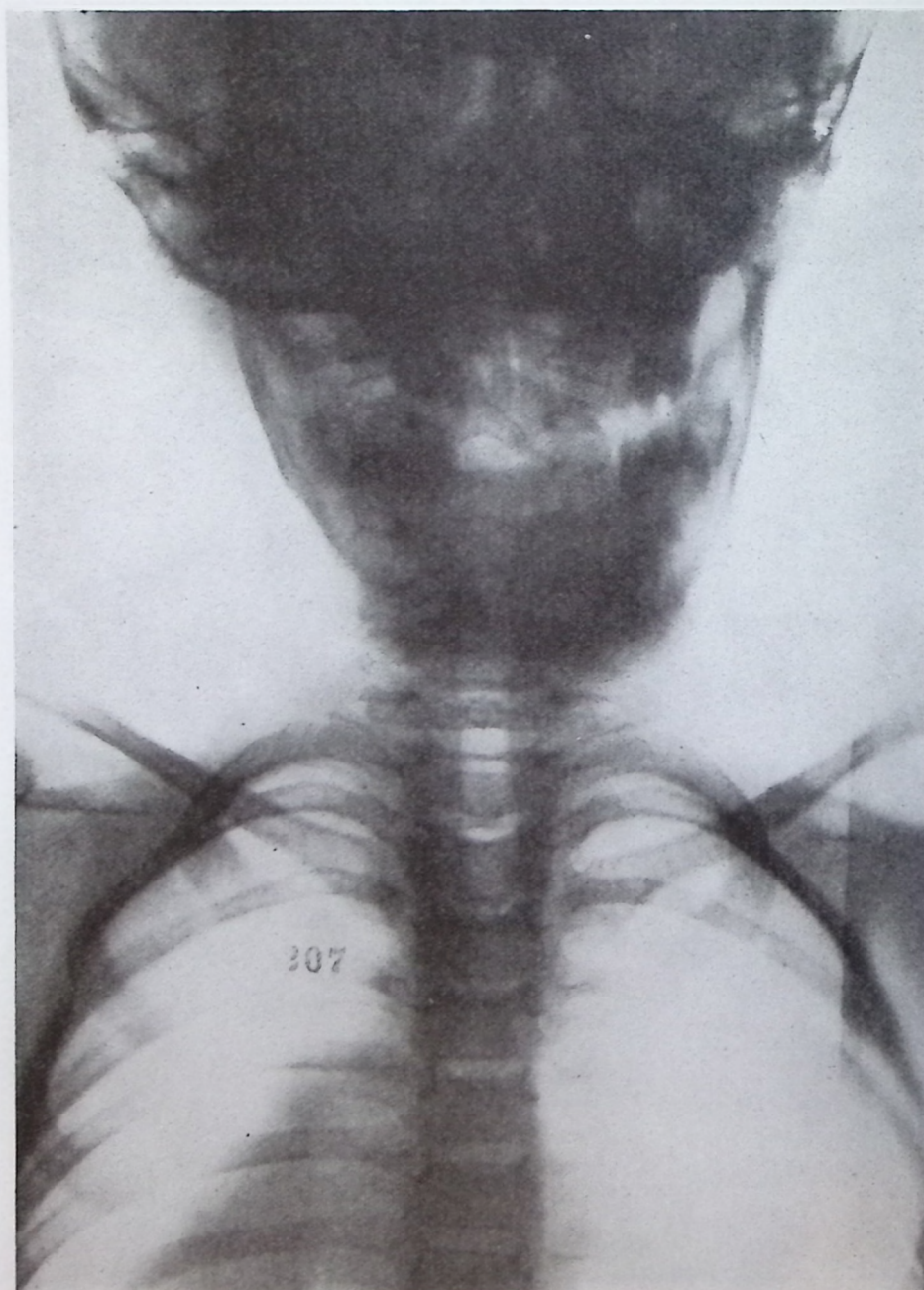


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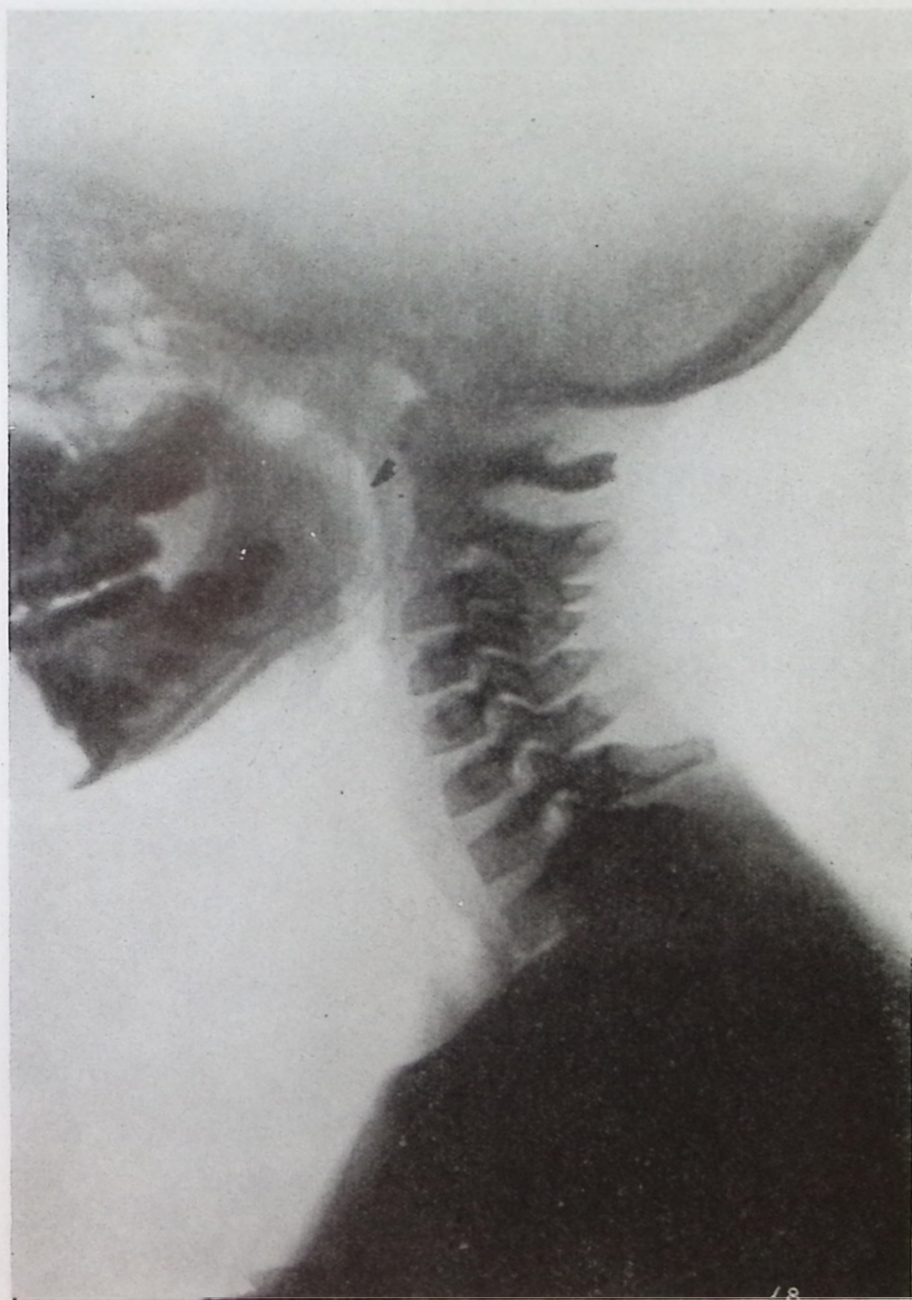


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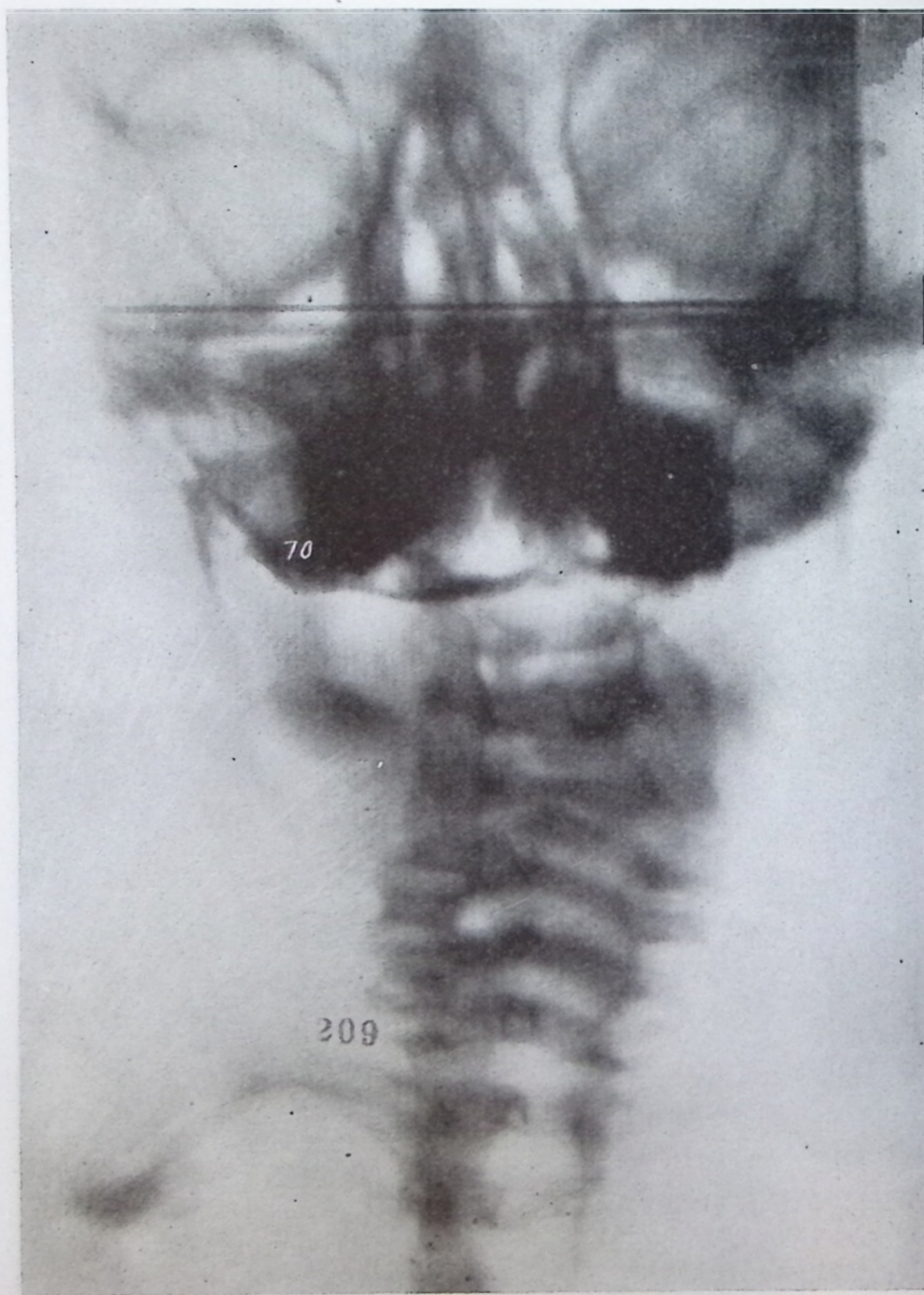


Illustration No. 209



Illustration No. 210

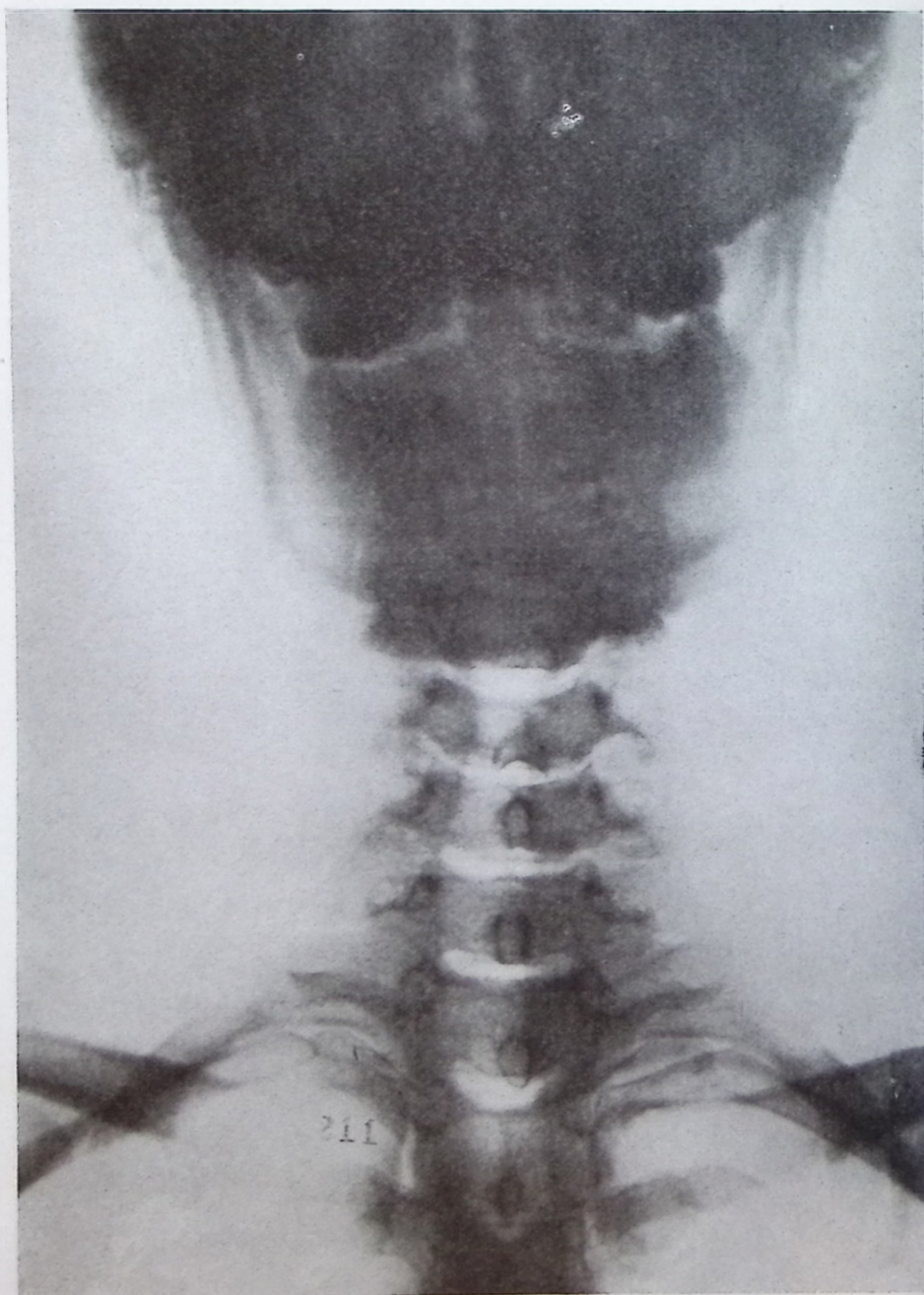


Illustration No. 211



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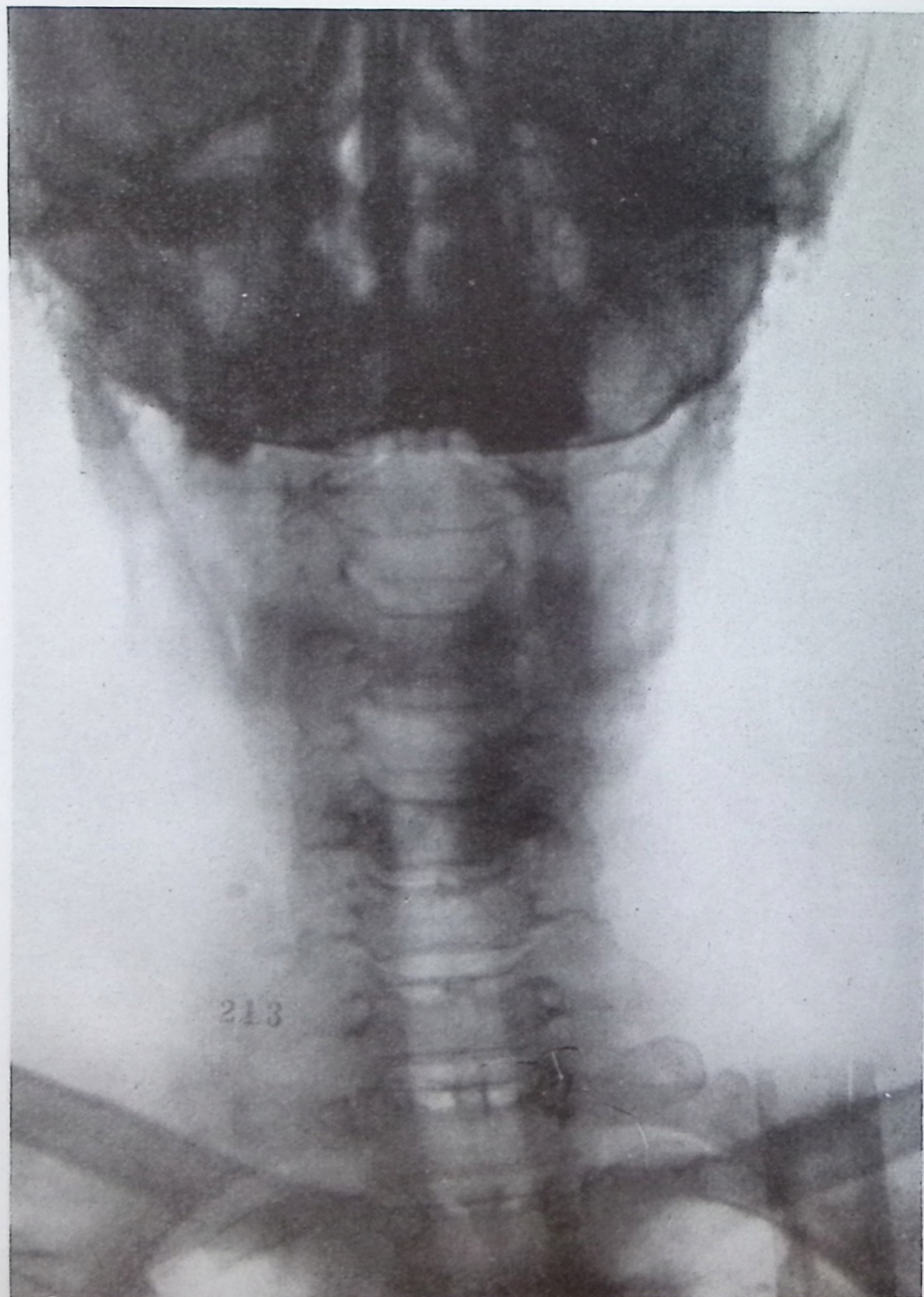


Illustration No. 213



Illustration No. 214

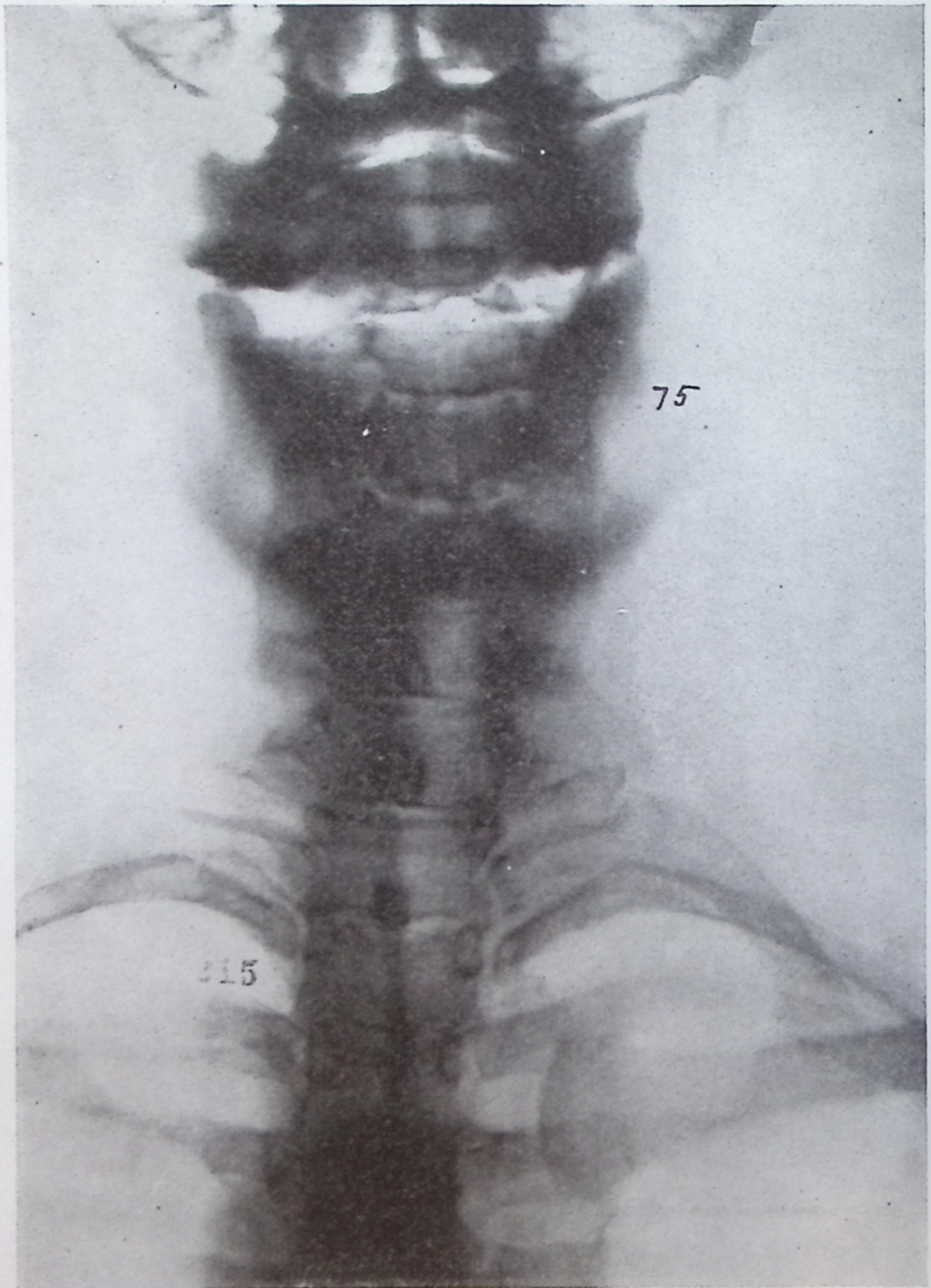


Illustration No. 215



Illustration No. 216

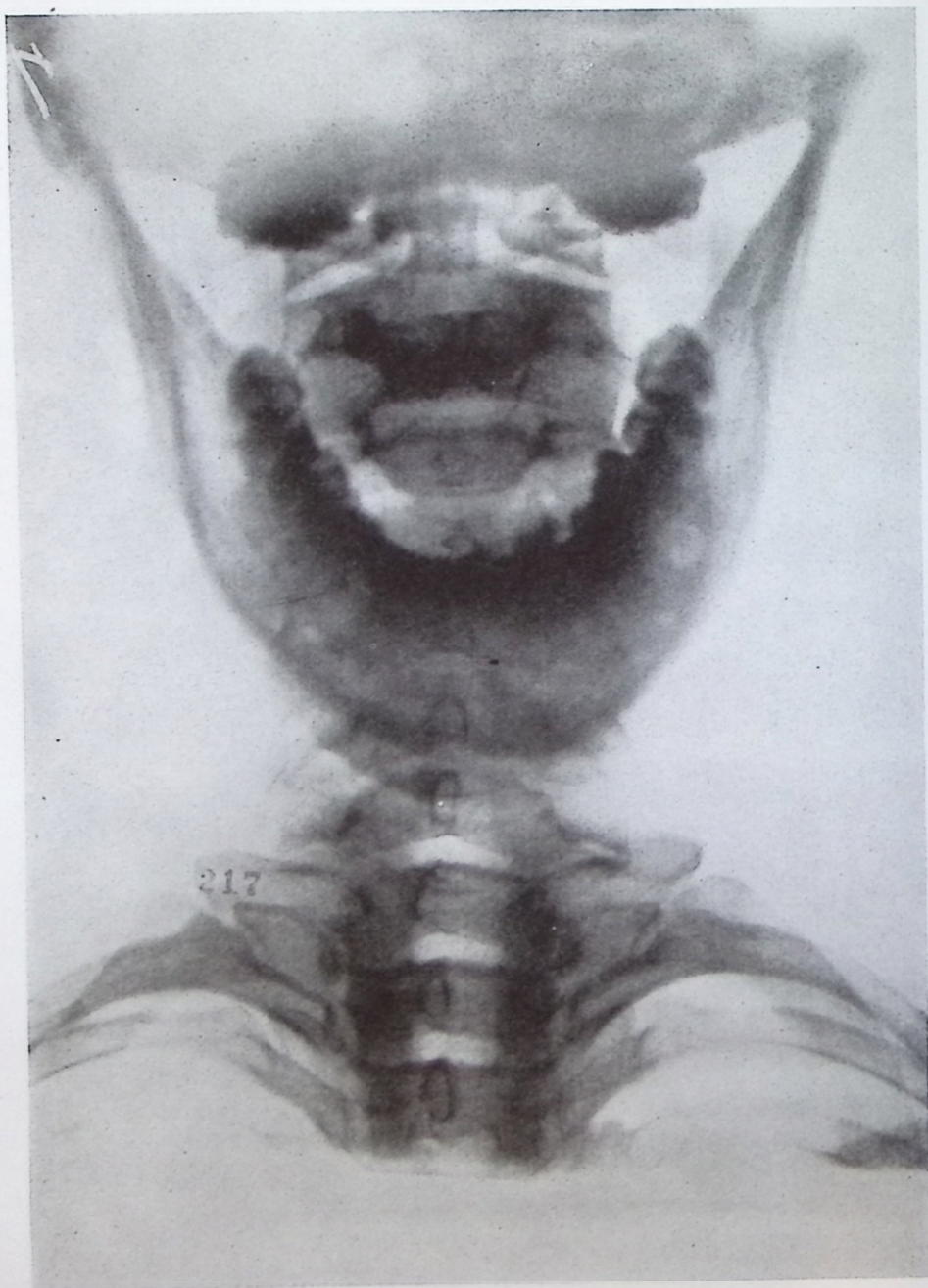


Illustration No. 217



Illustration No. 218

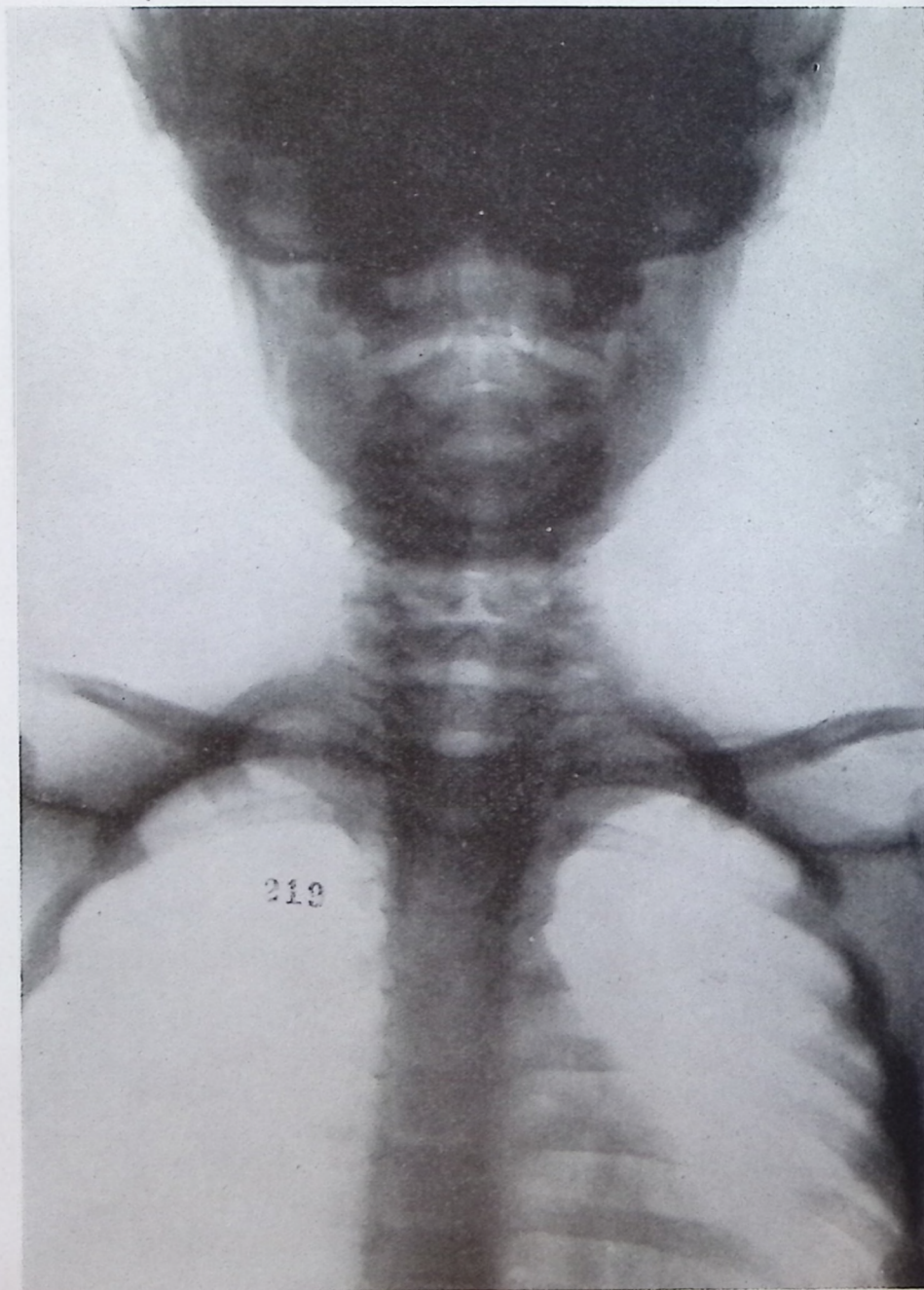


Illustration No. 219



Illustration No. 220

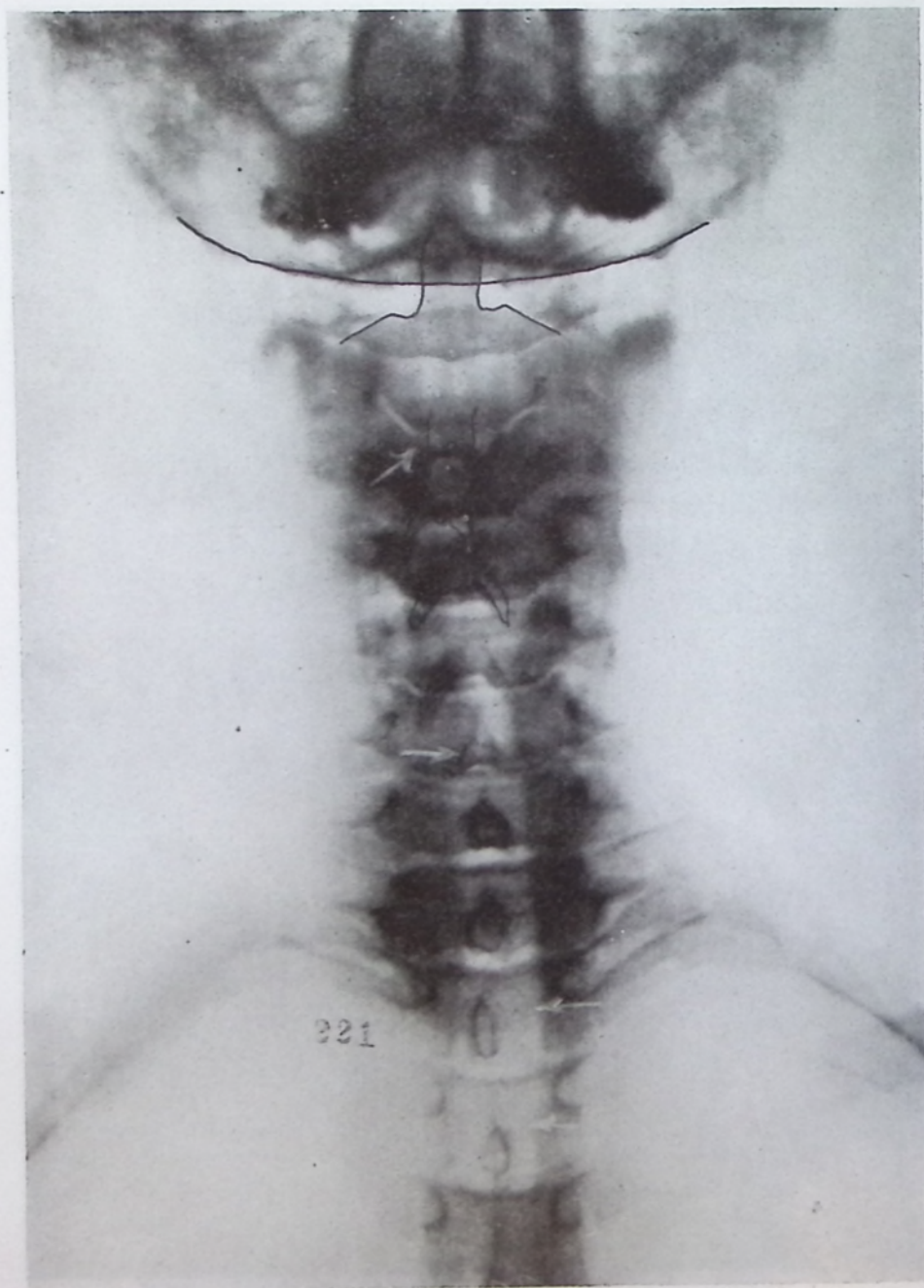


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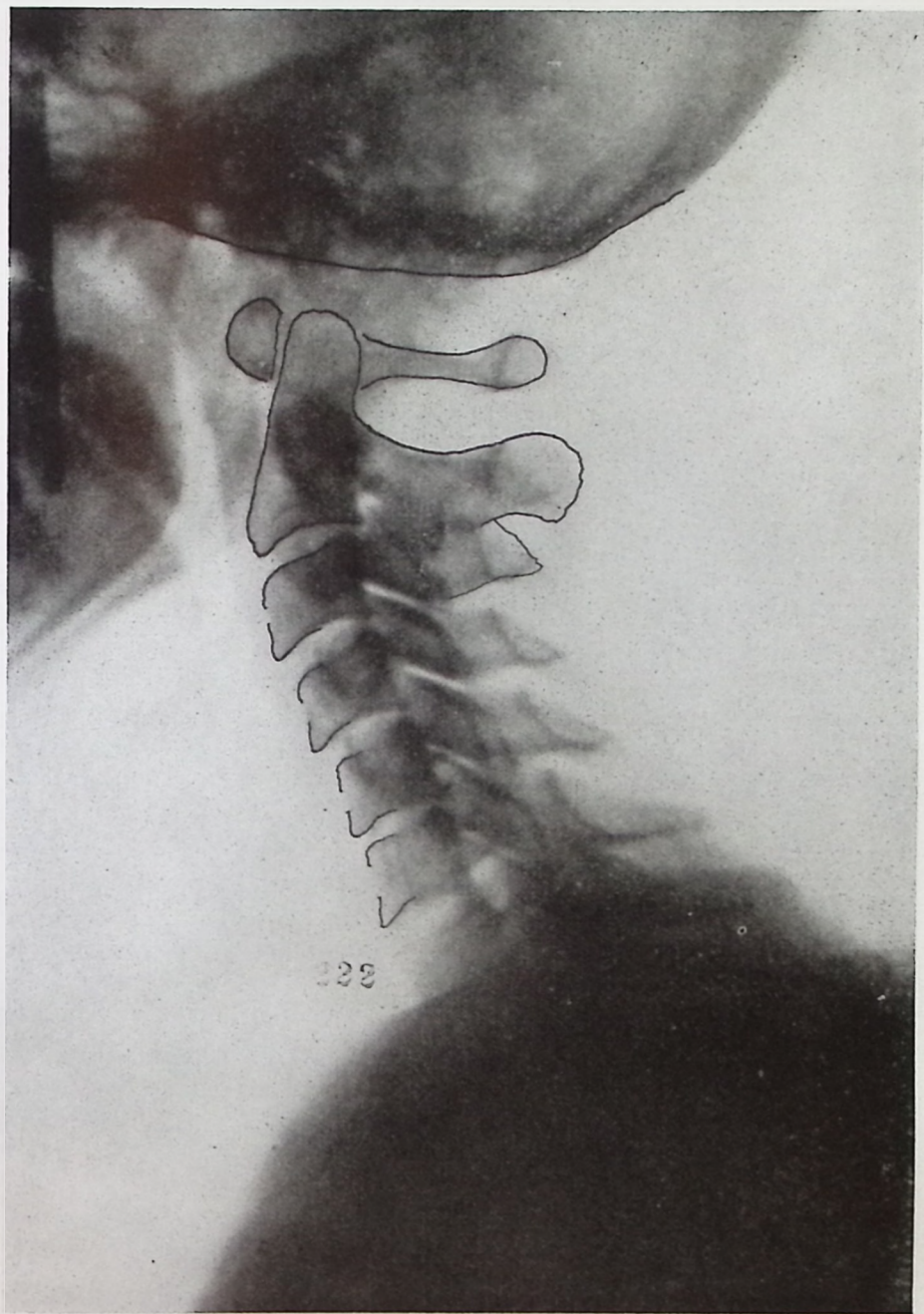


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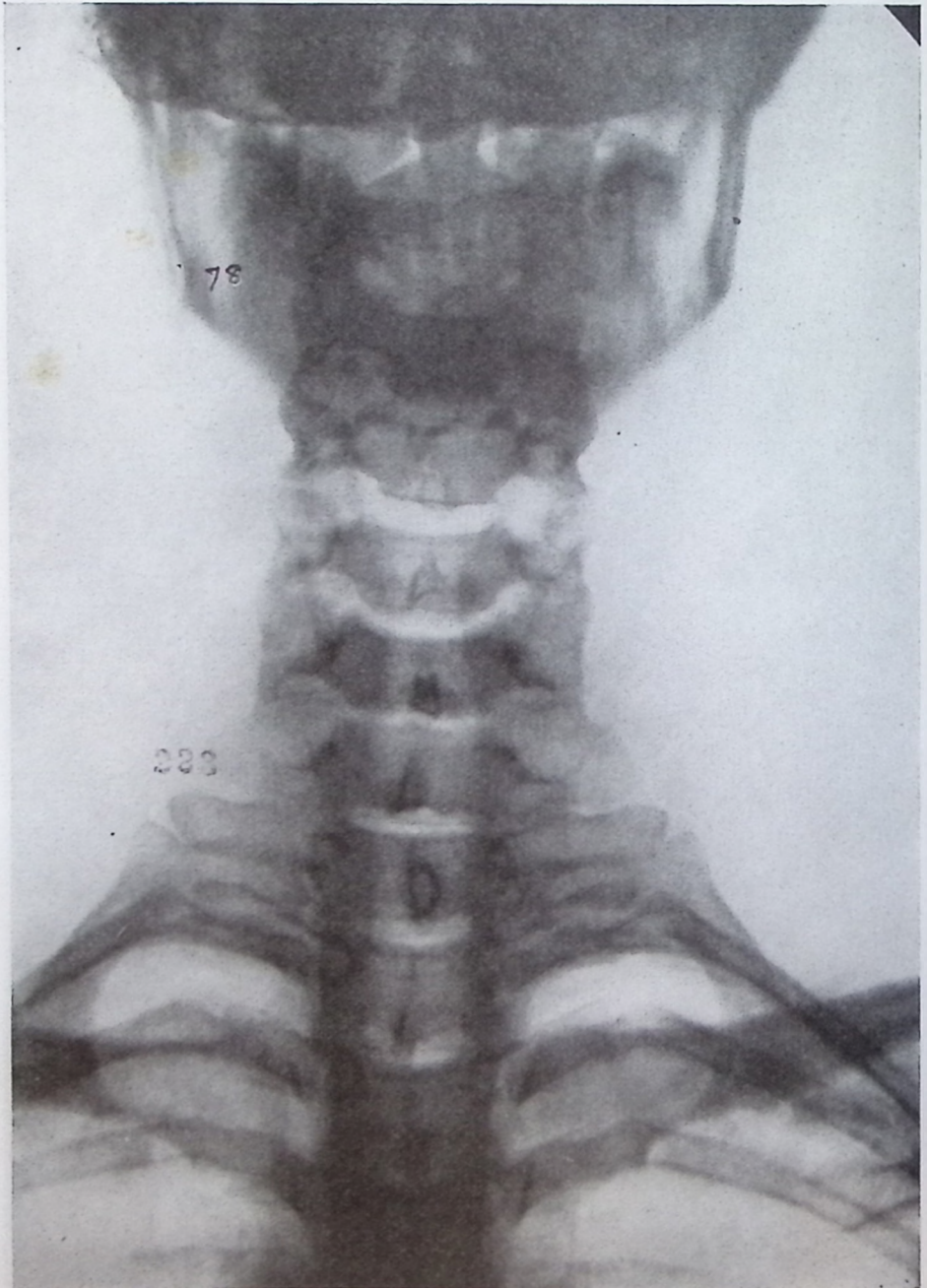


Illustration No. 223



Illustration No. 224

CHAPTER XXIV

AXIS PLI, FALSE SUBLUXATIONS



ILLUSTRATION No. 72. The basis for calling certain axis subluxations "false" is that spinous process IS in FALSE position. Reason for its being false is discussed under Chapter 10. This schematic pen and ink drawing shows head, atlas, and axis low on right, with spinous process to RIGHT of median line. (Read "Median Line" under Chapter II, to recall what is meant). This spinous process is where it SHOULD NOT BE. It is NOT where IT SHOULD BE. With a head, atlas, and axis low on right, spinous process of axis SHOULD BE to LEFT of median line.

We now present spinographic studies of actual cases to prove that such perversions to our axis rules DO exist and must be considered in listing subluxations. We know of no vertebral subluxation that can so easily fool us as these, in palpation. They palpate one way when in reality they are opposite; and outside of spinographic study, we have no way OF KNOWING. That it is vital TO KNOW, goes without saying. If palpation is relied upon, adjustment will be wrong. To adjust wrong is to make every such case worse.

Illustrations 73 and 74.

Head is low on right (A-P view).

Atlas and axis are low on right.

Spinous process is RIGHT of median line.

Spinous process should be LEFT of median line, to follow rule.

Lateral view shows axis spinous process VERY much inferior.

Listing would be Axis PLI, FALSE.

Adjustment would be from PLI as tho spinous process were on LEFT side.

Head, atlas, and axis must be raised on RIGHT side. Some superiority as well as laterality will be incorporated in this adjustment. Very inferiority of axis demands MUCH superiority in adjustment.

Illustrations 225 and 226.

Head, atlas and axis are low on right (A-P view).

Spinous process of axis is RIGHT of median line.

Spinous process should be left of median line to follow rule.

This makes it an Axis PLI false, IF lateral view sustains this axis as THE vertebra subluxated.

Lateral view shows spinous process of axis inferior, crowding on 3rd cervical spinous process and a forcible separation on anterior of centra between axis and 3rd cervical.

Axis spinous process (A-P view) should be to LEFT of median line. It IS right. It is not where it should be. Because head, atlas, and axis ARE low on right, spinous process of axis SHOULD BE left of median line to follow rule; hence adjustment would be from PLI as much so as the axis spinous process WERE to LEFT of median line.

Amount of laterality, in an adjustment where spinous process is false right when it should be true left, would be to exact opposite or reversed extent. In other words, if it WERE very much right, it should be adjusted as the very much left.

In this case, inferiority of spinous process (lateral view) takes precedence as it is far more inferior than is spinous process right or is head, atlas, or axis low on right.

Illustrations 227 and 228.

Head, atlas, and axis are low on right (A-P view).

Spinous process of axis is right of median line. It should be left, which makes it a false PLI axis.

Lateral view does not show axis crowding down upon spinous process of 3rd, therefore inferiority is not dominant in this subluxation. Laterality (A-P view) is more vital than is inferiority on Lateral view.

Lateral view gives one of those straight up-and-down perpendicular cervical regions.

It is adaptative in this position and is possibly more nearly normal than some others where it is badly curved lordotic.

Illustrations 229 and 230.

Head, atlas, and axis are low on right (A-P view).

Spinous process is to right of median line.

Whenever we find a head, atlas, and axis on right, and spinous process to right, it makes a false listing and should be regarded as tho spinous process were to opposite, or left, for it violates normal rule of where it should be.

Lateral view shows crowding of all spinous processes, throwing odontoid process back into neural canal of atlas. In this picture it is more so than usual, thus demanding considerable adjustment from inferior of spinous process of axis to get it back into normal alignment in relation to fovea dentalis.

Illustrations 231 and 232.

Head, atlas, and axis are low on right (A-P view).

Spinous process is to right of median line, violating normal or usual rule.

A-P view shows usual of adaptative curves in cervical region running true to form; curve being opposite to low side. If low on right, curve is to left.

Lateral view shows a more decided lordotic curve in this set than in previous ones.

Axis spinous process crowding more inferior on other spinous processes than in previous views.

In this Axis PLI, false subluxation, inferiority of spinous process (lateral view) is major direction to be corrected. There would be three times as much adjustment from inferior, under spinous process of axis, as there would be from left to right on spinous process of axis or anterior desiring to raise the head, atlas, and axis on right.

Odontoid shows an inverted V between anterior of spinous process of axis and posterior of fovea dentalis on anterior arch of atlas.

Illustrations 233 and 234.

Head, atlas, and axis are low on right (A-P view).

Spinous process is right of median line.

Lateral view shows axis spinous process inferior crowding upon 3rd cervical vertebra.

Compare positions of odontoid of Illustration 232, with odontoid of Illustration 234. In 232 it is an inverted V with wedge shaped larger below. In 234 it is larger above. In 232, base of

odontoid is producing pressure upon spinal cord. In 234 apex of odontoid is producing pressure. In both cases, adjustment would be the same. Adaptative conditions that would follow would differ. In 232 it would draw anterior arch of atlas inferior on anterior and thus fill up incorrect space. In 234 it would straighten relationship between odontoid and anterior arch of atlas and equalize space. In both instances odontoid would fit into fovea dentalis normally and release pressures upon spinal cord.

Comparisons between inferiorities of spinous processes of 232 and 234 are about the same and both would require approximately same amount of adjustment from under spinous process of axis, towards superiority, to correct them. Actual difference in position of relationships of odontoid processes is brought about by differences in curves of adaptative cervical region. In 232 it is curved lordotic; in 234 it is approximately perpendicular except for torque between axis and 3rd cervical.

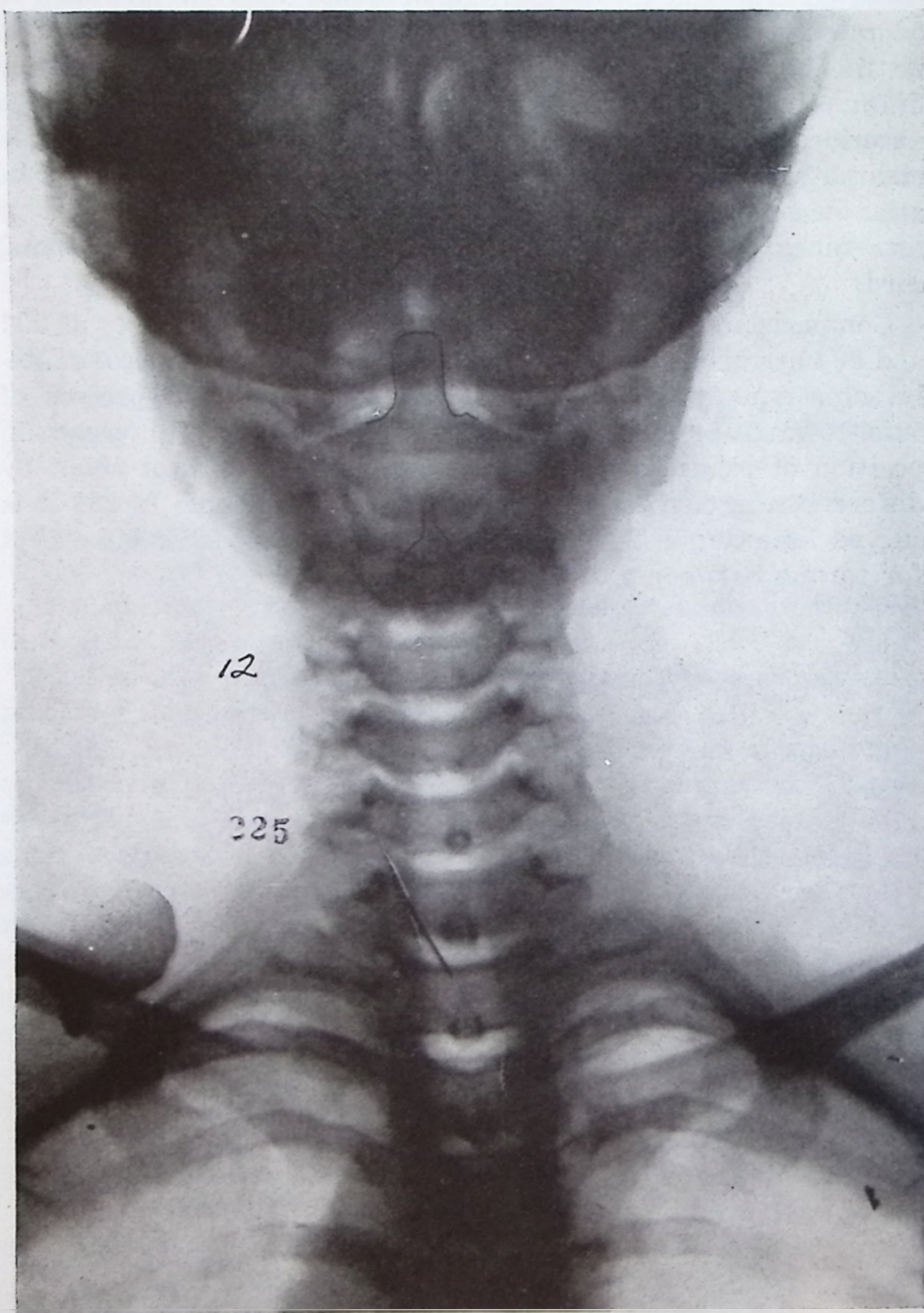


Illustration No. 225



Illustration No. 226

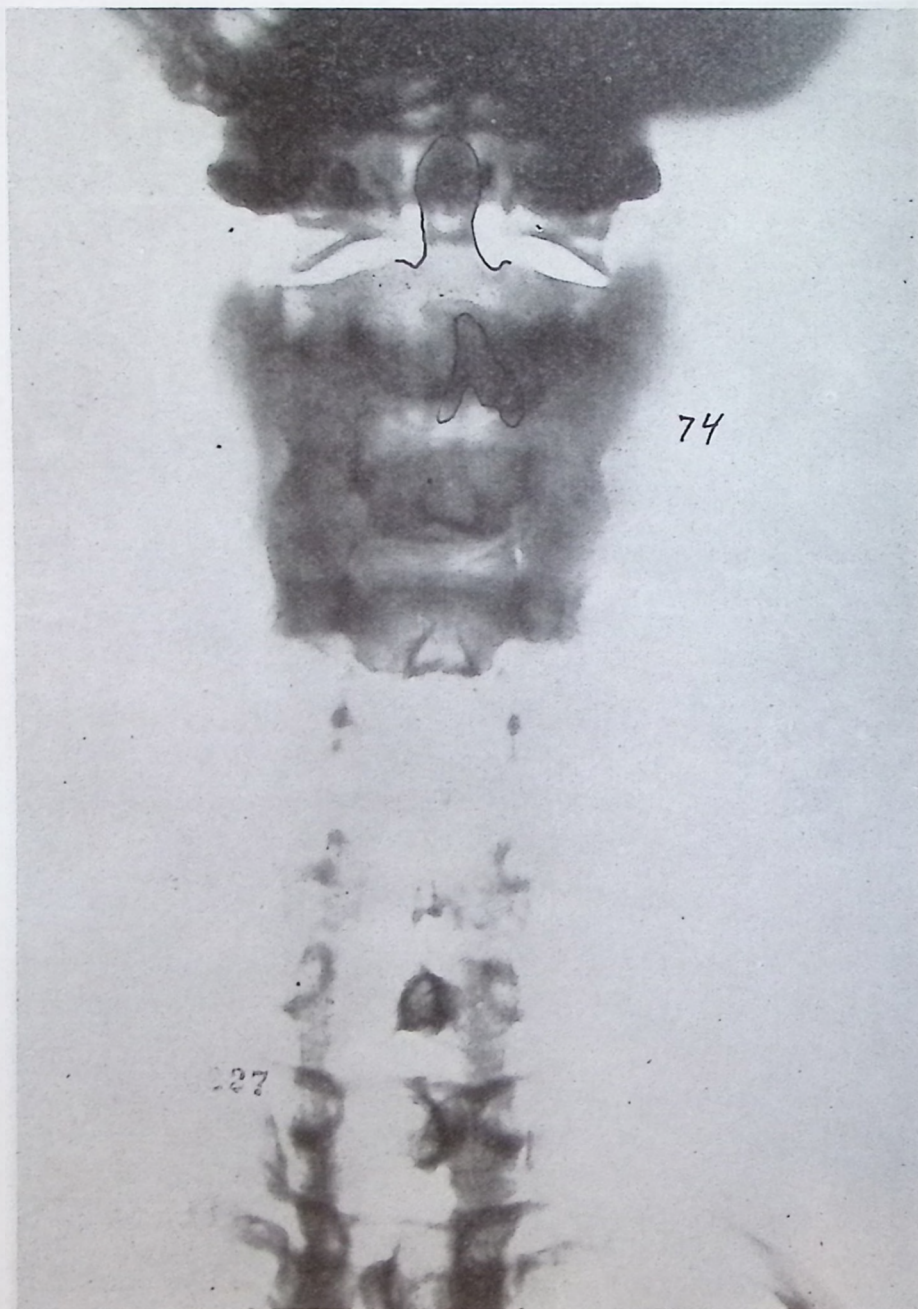


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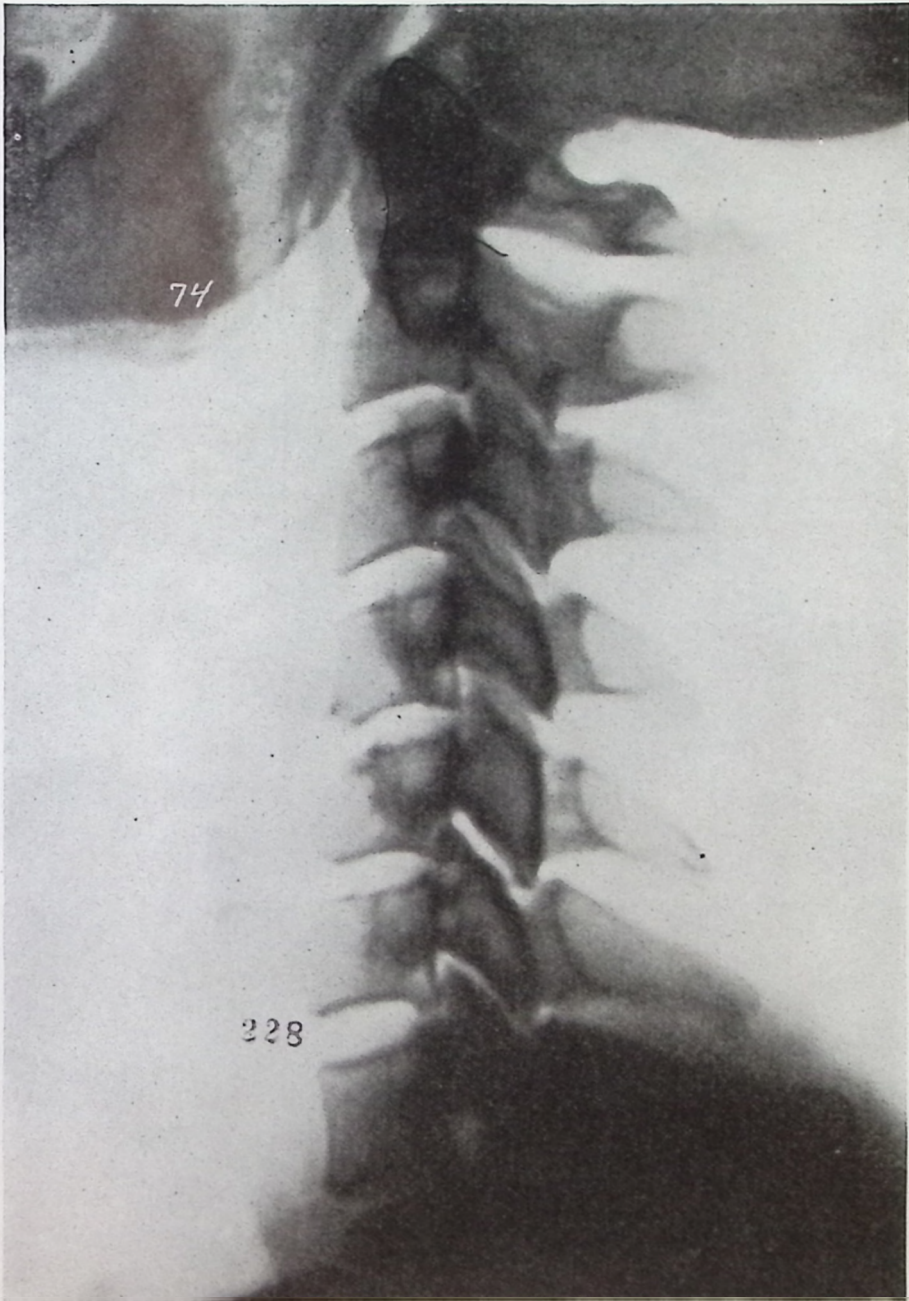


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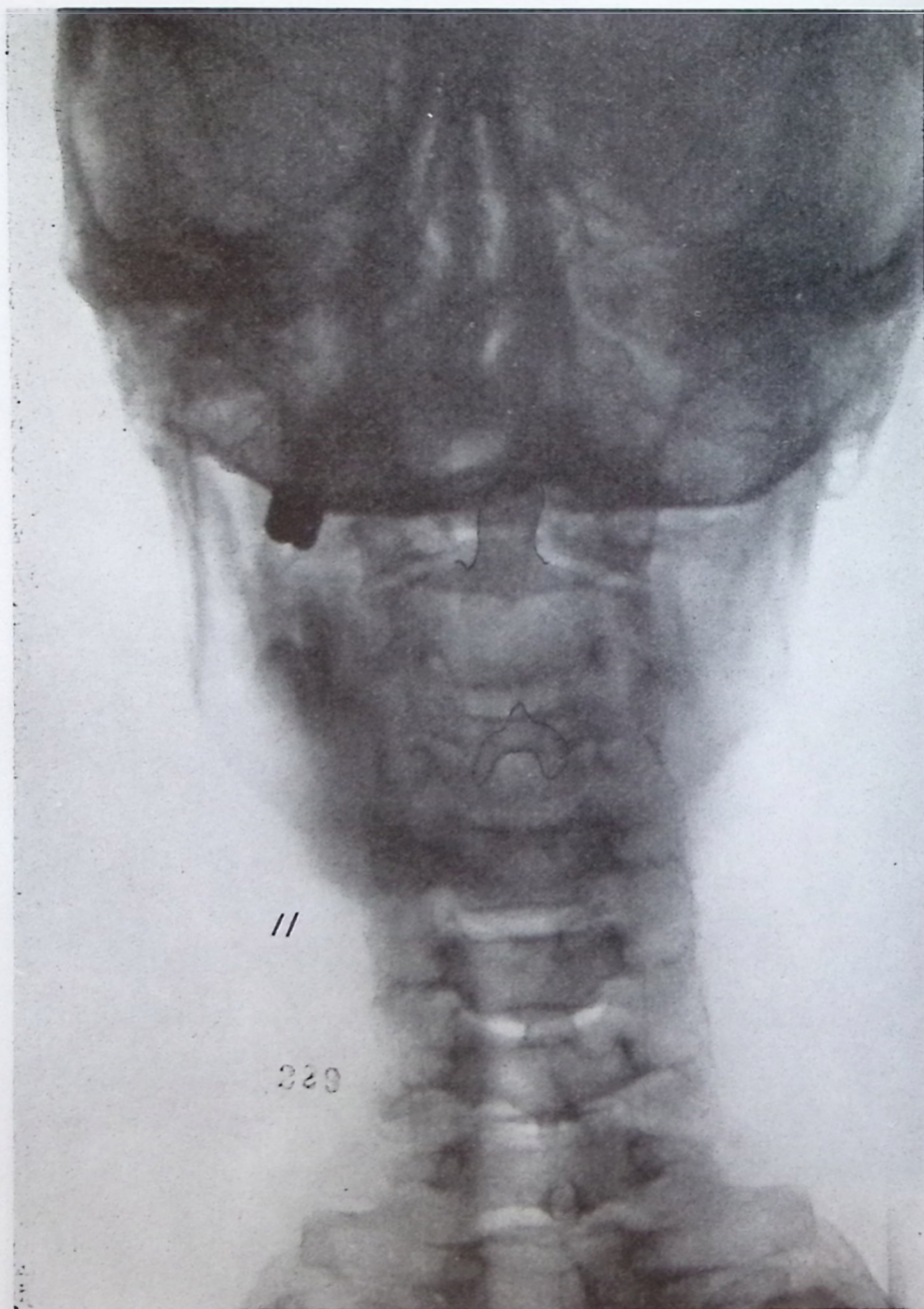


Illustration No. 229



Illustration No. 230

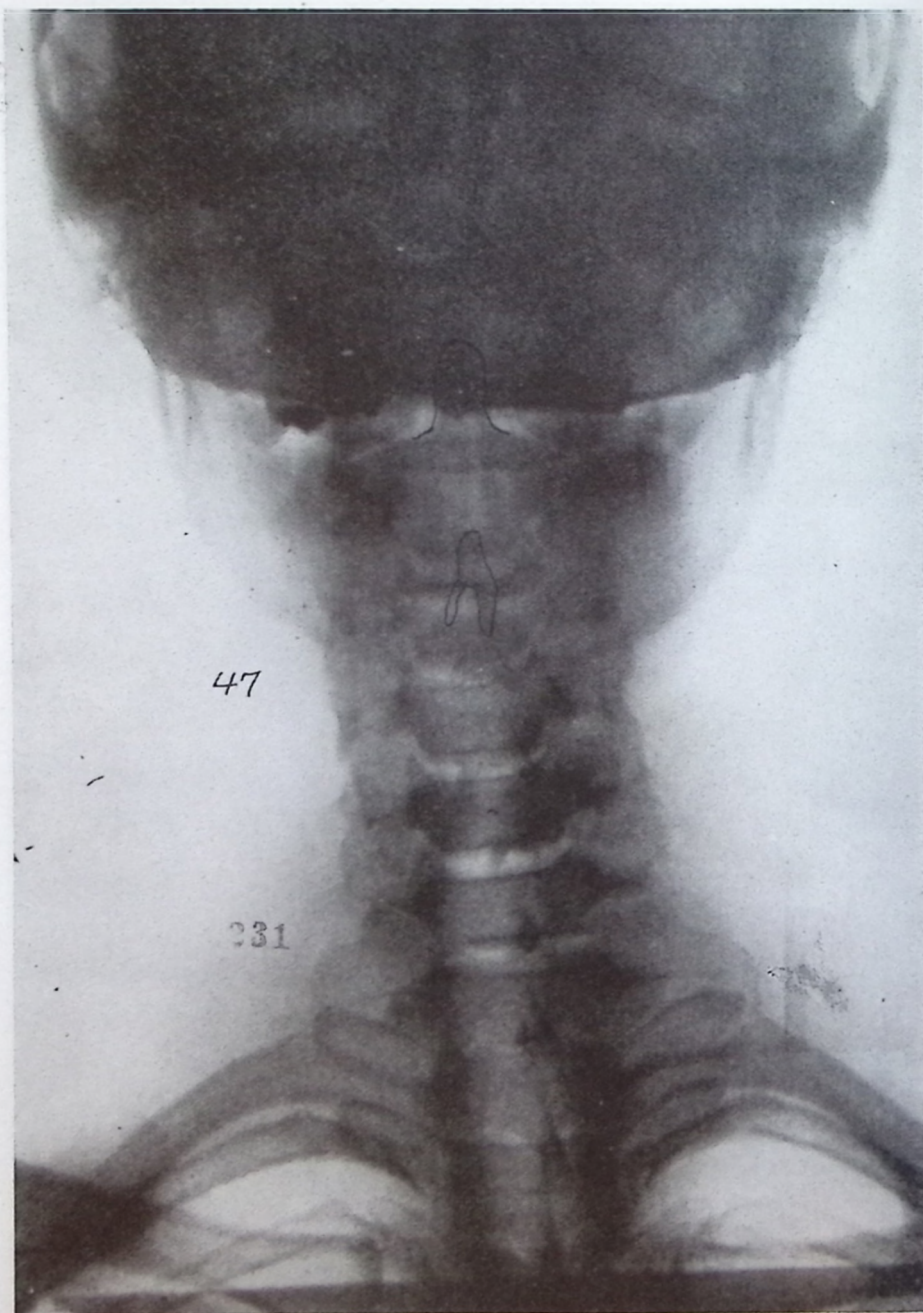


Illustration No. 231



Illustration No. 232

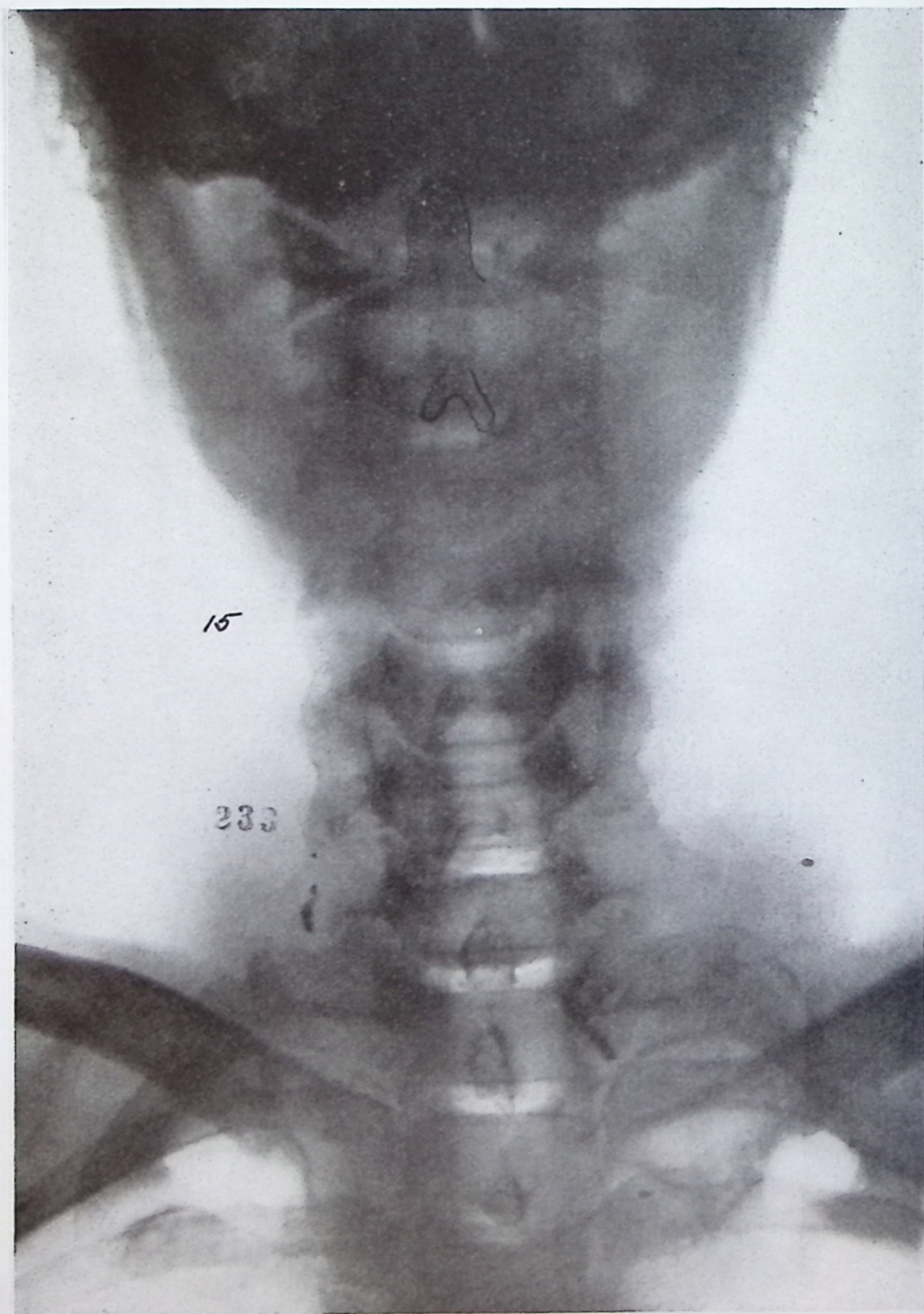


Illustration No. 233



Illustration No. 234

CHAPTER XXV

AXIS PRI, FALSE SUBLUXATIONS



WHEN we refer to term "axis, PRI, false" we mean to imply (which is explained elsewhere in this book) that the portion of the axis, minus spinous process, follows the rule. The spinous process, however, violates the rule. Body of the axis IS subluxated PRI, only spinous process of axis being found to left.

Schematic pen and ink drawing, Illustration No. 75, exhibits this fact. Head, atlas, and axis are low on left. Body of axis, minus its spinous process, is to right of its normal position. Spinous process, however, has a bend in it which throws it back to left. In giving an adjustment, you do not adjust spinous process, but you DO adjust body of vertebra for it is in and on that body that odontoid process exists; and it is that odontoid process that is producing damage by way of pressure and interference. Some Chiropractors have the fallacious idea that it is THE SPINOUS PROCESS that you adjust. As a matter of fact, you don't even adjust BODY OF AXIS. What you NOW adjust is LOCATION AND POSITION OF ODONTOID PROCESS.

Illustrations 76 and 77.

Head, atlas and axis are low on left.

Spinous process is to left of median line.

Slightly scoliotic right cervical compensatory curve is present.

Lateral view shows spinous process inferior on 3rd cervical vertebra. Axis odontoid, therefore, is back into neural canal.

Here is an average subluxation. Little tilting of head, atlas, or axis on left; not much spinous process to right (for adjustment) and axis spinous process is not badly inferior (lateral view); still, in spite of these slight conditions, odontoid is creating great interference.

In listing, this subluxation is called "axis PRI false"; however, for purpose of adjustment, it would be listed as tho "axis PRI." To express relative values of three directions, PR and I plus.

Illustrations 235 and 236.

The same conditions, to about same degree as in Illustrations 76 and 77. Each of the directions is of same approximate evaluation.

In listing, this subluxation is called "axis PRI false"; however, for purpose of adjustment, it would be listed as tho "axis PRI." To express relative values of three directions, PR and I plus.

Illustrations 237 and 238.

The A-P view of this set is quite similar to that of 76 and 235. Lateral view shows a slight change. In 235, as cervical approaches superior sections, there was a decided bend posterior. In 238, it continues to go on up straight, and there is practically no bend in this straight line until we reach atlas. Yet there is still a marked deflection in position of odontoid in both instances.

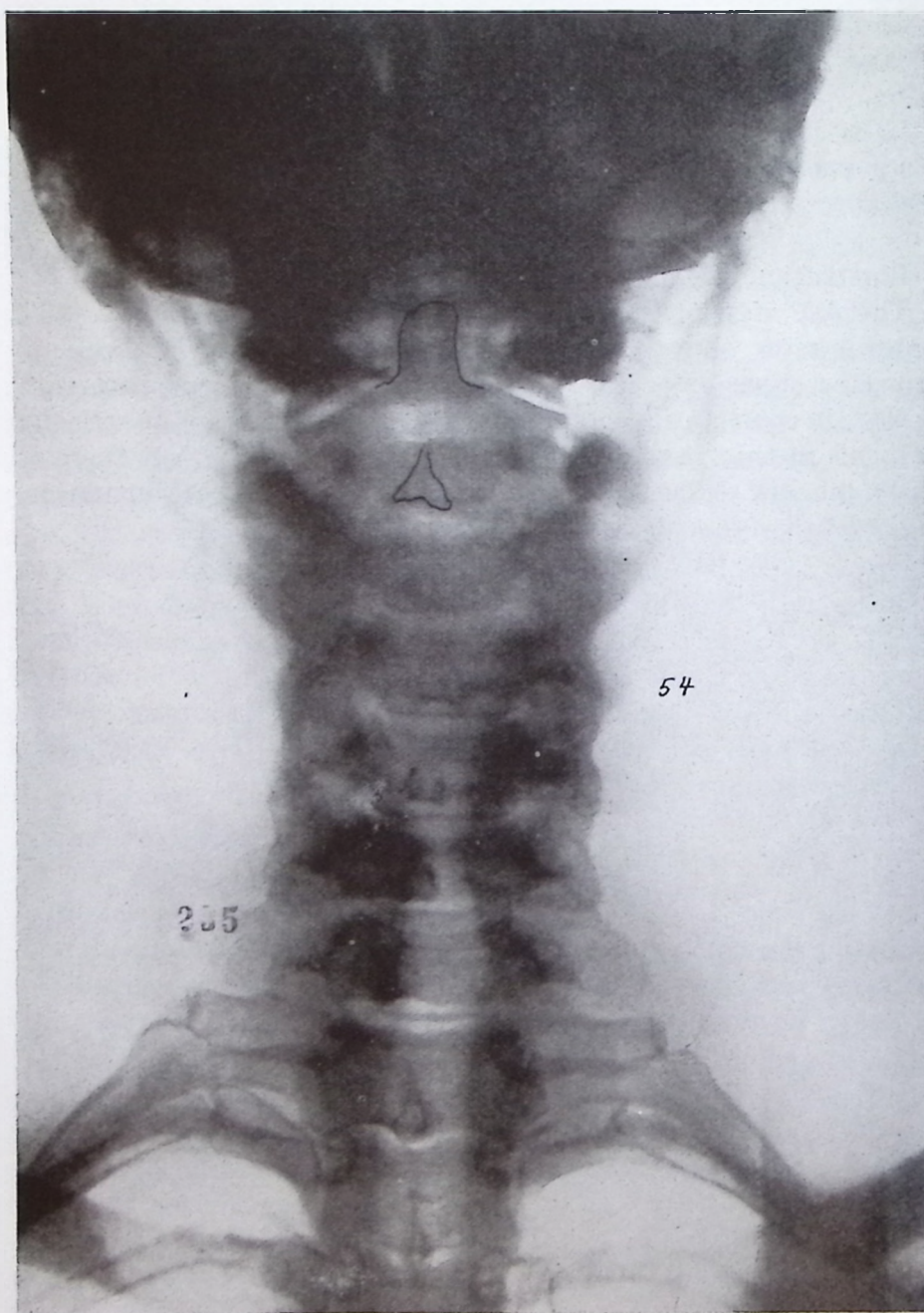


Illustration No. 235



Illustration No. 236

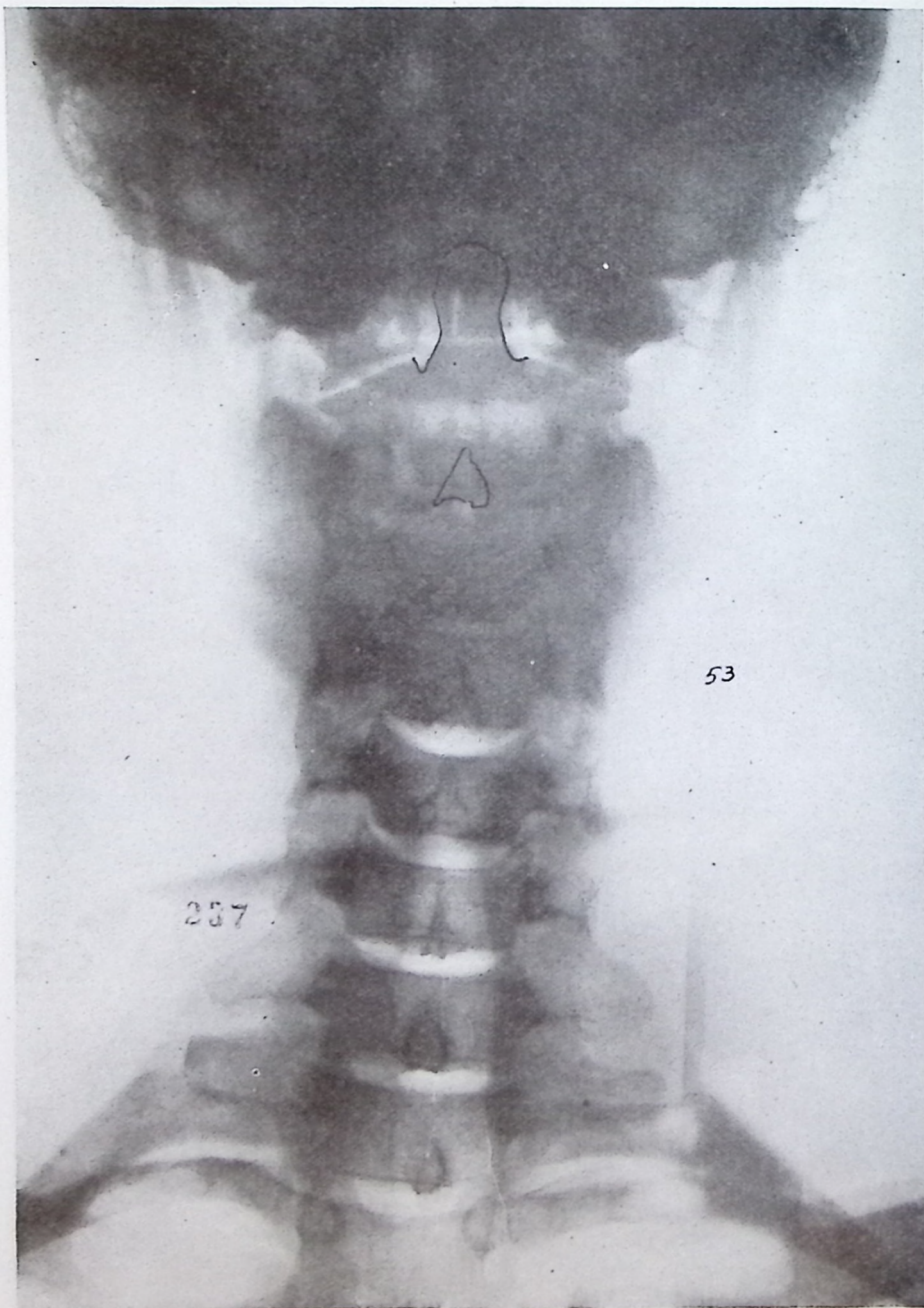


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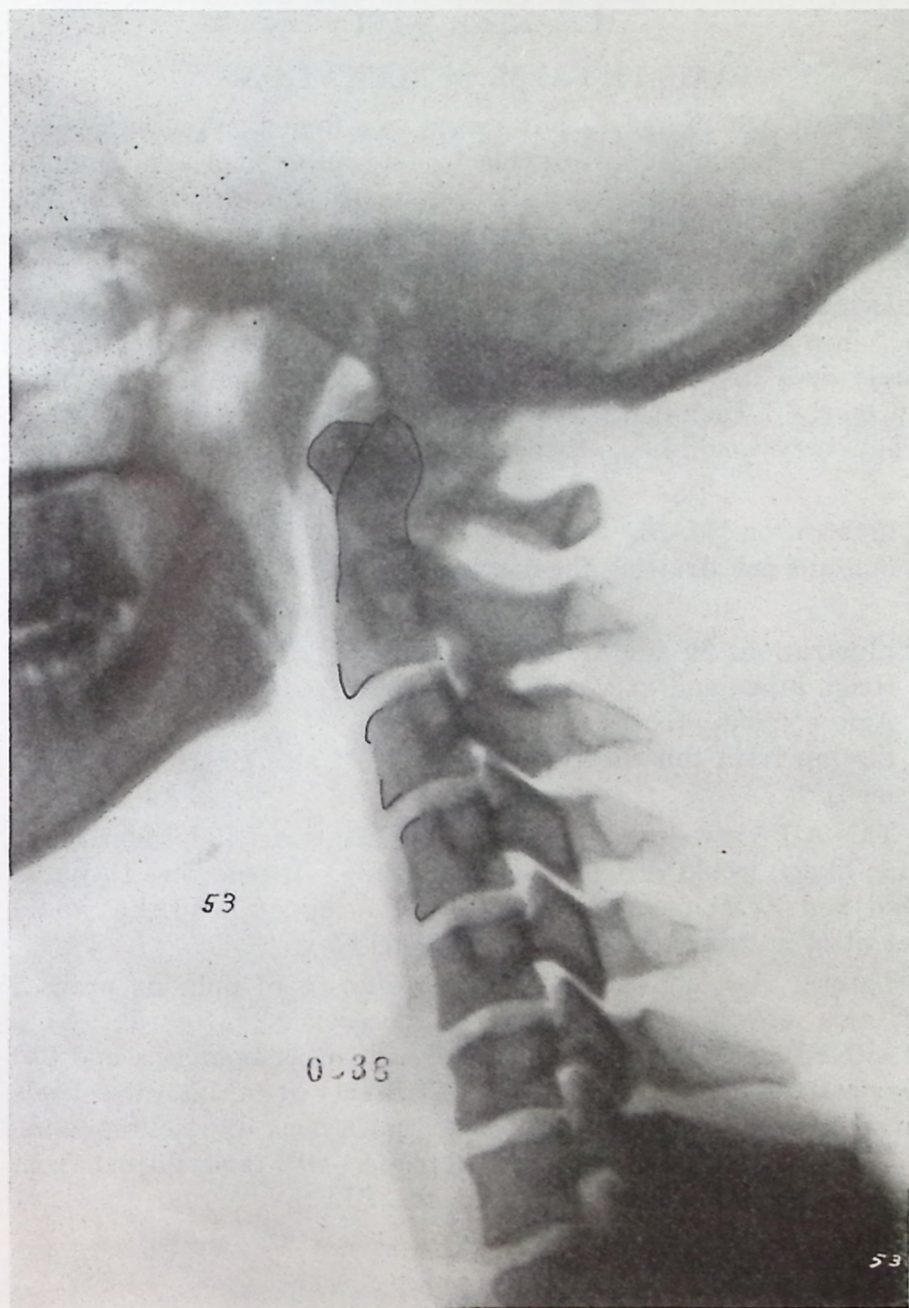


Illustration No. 238

CHAPTER XXVI

AXIS PI, FALSE SUBLUXATIONS



OCASIONALLY, but rarely, we find axes subluxations wherein we are unable to determine that axis spinous process is either to left or right of median line. We may have head low on left or right, atlas and axis low on left or right, with spinous process IN median line. This makes it a "false." In this event, we list spinous process to follow rule, i.e., if head, atlas, and axis are low on left, it would be a RIGHT spinous process; if head, atlas, and axis are low on right, then it would be a LEFT spinous process. In either event, they would be so listed.

Illustration No. 78.

Pen and ink drawing illustrating above.

Illustrations 80 and 81.

Head, atlas, and axis are low on right (A-P view).

Axis spinous process is in median line.

Listing from this view only would be "False PI axis. Adjust from L."

This A-P view shows little if any subluxation. Palpation, more than likely, would reveal little if anything. If one were to judge kind and location of subluxation by tilting of head, he would get little in this case to gratify his curiosity.

Lateral view shows MARKED inferiority of spinous process of axis crowding down upon 3rd cervical vertebra. Note MARKED separation on anterior of centra between axis and 3rd cervical vertebra. Altho A-P view reveals little, lateral reveals an odontoid process crowding VERY much back into neural canal.

Listing on this subluxation would be Axis PI false, adjust from L. The evaluations would be PI and L PLUS.

Illustrations 239 and 240.

Head, atlas, and axis low on right (A-P view).

Axis spinous process in median line.

Listing from this view only would be "False PI axis." Adjust from L.

Cervical curve is to right (Lateral view). If this be taken as a guide, axis would be adjusted from R rather than from L, which proves that all rules will not always apply.

This A-P view would be one of those "border-line cases" which even experts might differ upon. I prefer following "head, atlas, and axis low on right," throwing axis spinous process to L and adjusting from L.

Lateral view shows axis spinous process inferior but not as much so as in Illustration 81. Odontoid process is posterior into neural canal.

Listing on this subluxation would be "Axis PI, false, adjust from L." Evaluations would be PI and L PLUS.

Illustrations 241 and 242.

Head, atlas, and axis low on right (A-P view).

Axis spinous process is in median line.

Listing from this view only, would be "False PI axis. Adjust from L."

Cervical curve is to left. (Lateral view). If this be taken as a guide, we fall back upon usual rule because it follows it. With head, atlas, and axis low on right, axis spinous process should be to left. In this instance, axis would be adjusted from L. I would follow this rule as it is the majority condition and safer to correct.

Lateral view shows axis spinous process inferior with about equal degree as in Illustration 240.

Evaluations would be PL and I plus.

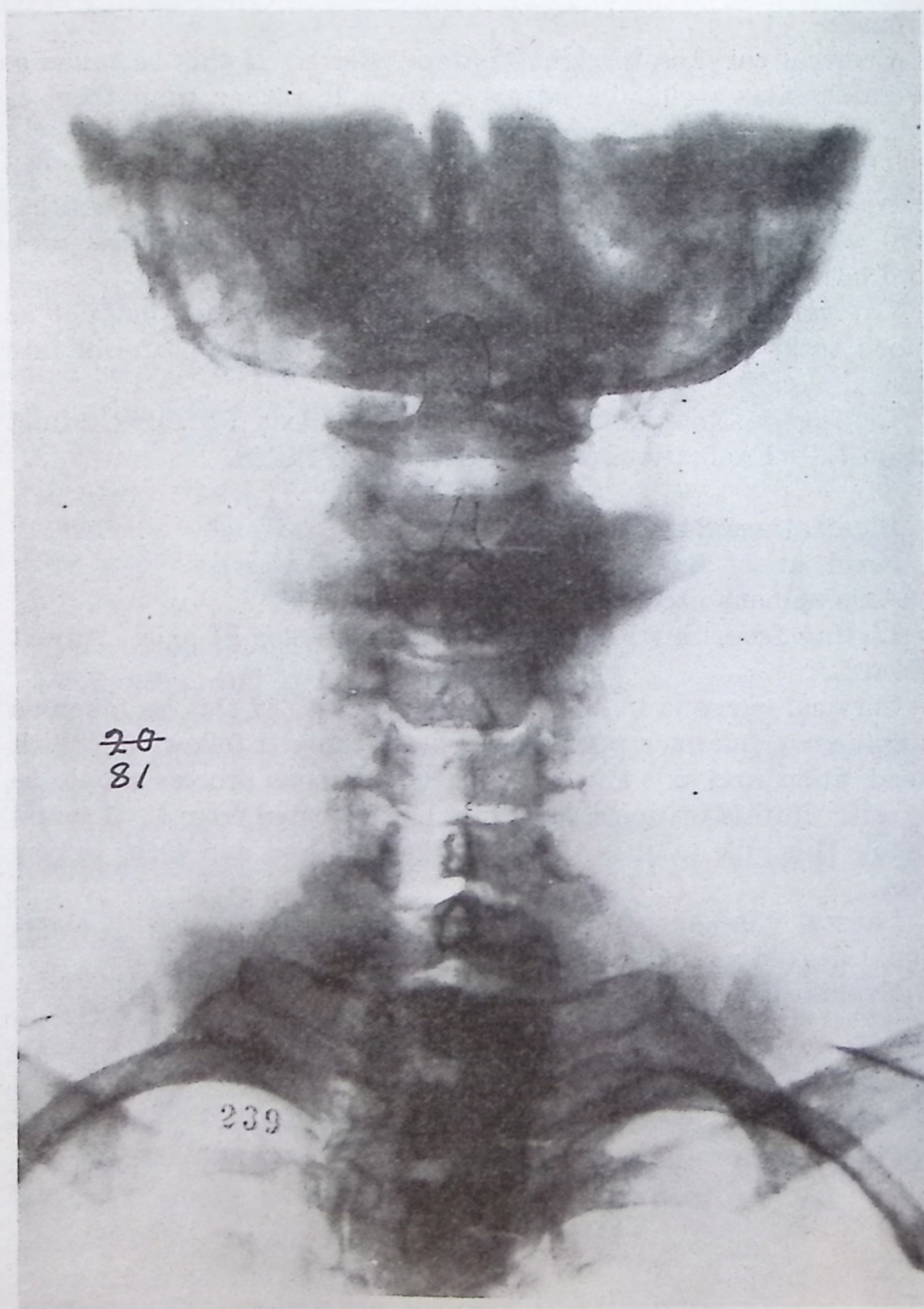


Illustration No. 239



Illustration No. 240

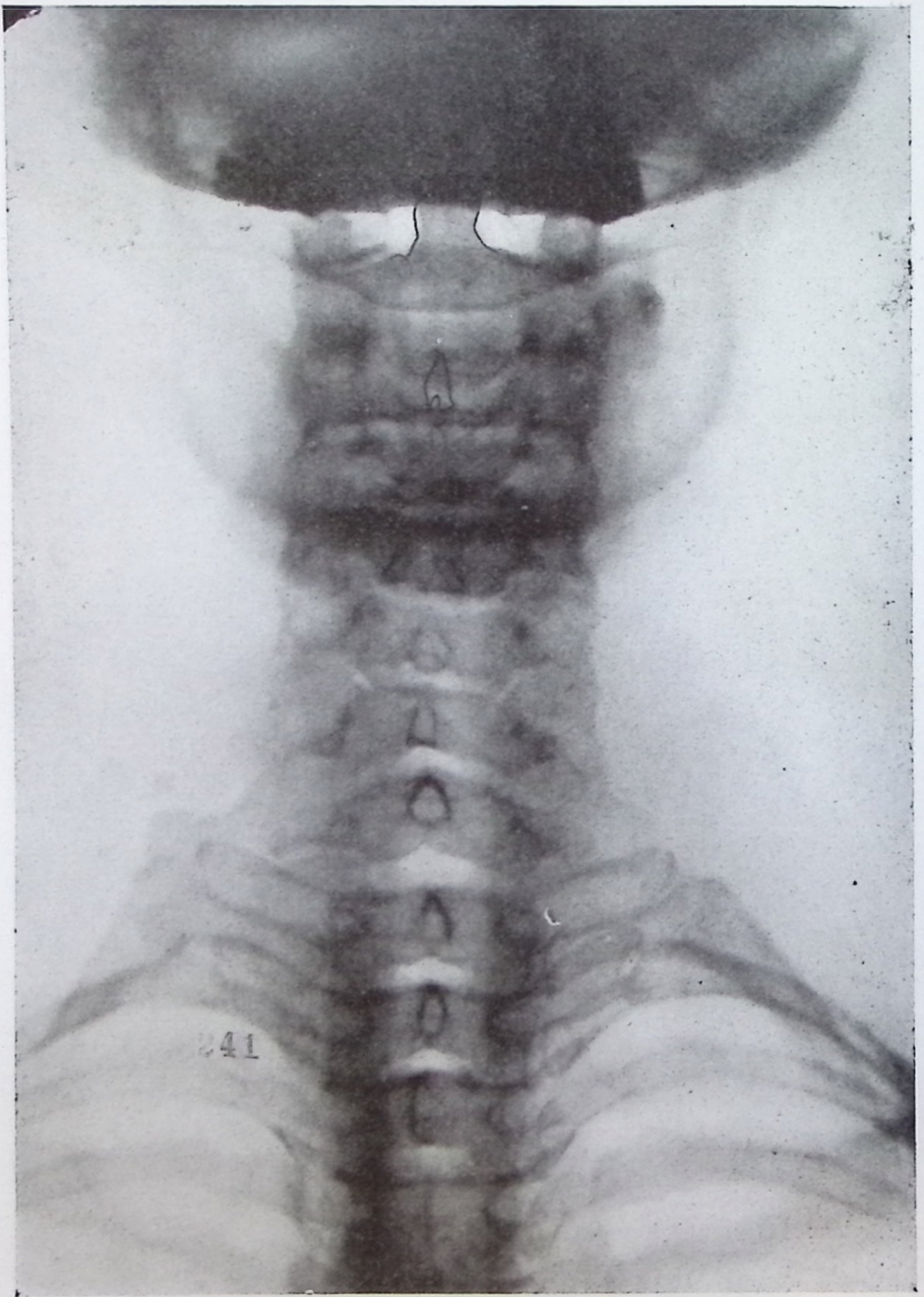


Illustration No. 241



Illustration No. 242

CHAPTER XXVII

ATLAS AIR-AIL SUBLUXATIONS



TO complete the broad scope of purpose of this book, we have seen fit to classify ATLAS subluxeations into TWO groups; those which now follow and those which follow later under title WEDGE-SIDE-SLIPS. If, in study of these illustrations, our reader decides that one shown here should be correctly classified as a wedge-side-slip, more than likely we would agree and take it as such by preference, feeling that we would be rendering a greater service to adjust it as a wedge-side-slip. It might be listed here as an "AIR" or "AIL" and be such in fact but should be described under other heading. There will be no quarrel if such is done. It might go so far as to be a right or left low wedge-side-slip and not come within this description which follows. If such is true, there again will be no quarrel.

Illustration No. 82 is a schematic pen and ink drawing to illustrate what is meant by atlas being torqued anterior and inferior. Lateral view does not show whether left or right side is inferior. If left side is inferior (observed on A-P view) then it would be listed as Atlas AIL. If right side is inferior (observed on A-P view) then it would be listed as Atlas AIR.

Before going into this study of torqued subluxeations of atlas, I suggest the reader again go back to Chapter X and review atlas rules for application to know which is which.

There are TWO general positions of these vertebrae: atlas anterior OR axis posterior. Being anterior, it can be superior or inferior ON ANTERIOR. By "anterior" is meant reference to anterior arch and ITS position in reference to odontoid for THAT is always one of THE vital factors.

Illustration No. 82 shows anterior arch of atlas, anterior and inferior in relationship with odontoid of axis as well as anterior and inferior in relation to condyles of occiput.

In all atlas spinographs, we study lateral first, then A-P view. They will be so arranged here.

Illustrations 83 and 84.

Lateral view shows head much inferior on posterior. If head were superior, in normal position where it belongs, posterior arch of atlas would be more superior than it is. If it WERE superior, anterior arch would be more inferior than portrayed. If it were possible to pull head forward, down on chin, posterior arch of atlas would raise; spinous process of axis would raise; hence origin of "anterior arch of atlas being ANTERIOR INFERIOR." As picture reveals, anterior arch is more superior than posterior arch, but you cannot judge whether anterior arch is superior or inferior entirely by position of it as compared with posterior arch. Position of head has much to do in such determination.

Lateral view shows axis spinous process posterior and inferior; but in an atlas anterior and inferior, with head backward and inferior as is, this position of axis becomes adaptative and compensatory to atlas torqued subluxation anterior and inferior.

Atlas being anterior and inferior, the inferiority (A-P view) is on R. Head is low on right and so is atlas. Listing would be (lateral view) atlas anterior and inferior: (A-P view) low on right; therefore AIR.

Illustrations 85 and 86.

It will be easier to ascertain correct position of this lateral view because anterior arch of atlas is anterior and IS more inferior on anterior arch than is posterior arch. Posterior arch IS superior. Anterior arch is torqued in its subluxation with anterior arch to anterior and inferior.

A-P view shows head, atlas and axis low on left; therefore INFERIOR ON LEFT. This would make listing Atlas (lateral view) anterior and inferior on anterior arch; and (A-P view) low on left; therefore AIL.

In illustrations 84 and 86, both odontoid processes of axes are posterior into neural canal because of anteriority of atlas. That one is left inferior and other right inferior, does not change the fact of abnormal position of odontoid process.

The vital objective would be to correct subluxation of atlas, in both instances, to correct the abnormal position of odontoid process of axis, to get it back into its normal fovea dentalis. Vital adjustment lies in correctly delivering the adjustment upon

transverse process; on left in one instance, upon right in the other. (See Chapter on Adjusting Technique).

Illustrations 243 to 248 inclusive are atlas subluxations AIR.

Illustrations 243 and 244.

(Lateral view) Anterior arch of atlas is inferior.

Posterior arch is superior, throwing odontoid process posterior into neural canal of atlas.

In former pages, we referred to moving of atlas wedge between head above and axis below. Here is a good example of just that. Head is posterior and inferior. Axis is posterior and inferior. Anterior arch of atlas is anterior and inferior. Between these three, odontoid process is forced posterior into neural canal of atlas.

A-P view shows head, atlas, and axis low on right. This would list atlas as AI on R, because it is RIGHT side that is inferior.

To adjust right transverse process from inferior (A-P view) would be to raise head, atlas, and axis. To adjust on right transverse from anterior inferior (AI) (lateral view) would be to correct it to its posterior superior normal relationship with occiput AND axis. It would raise inferior to superior; adjust anterior to posterior, and all would adjust fovea dentalis back into its odontoid—a peculiar way of expressing it, but nevertheless true.

Illustrations 245 and 246.

The subluxation here is similar to that of 243, except that it is more inferior on anterior and posterior arch is more superior. Head (A-P view) is low on right as was 248. There is one marked difference between these two sets of spinographs, viz., cervical is more straight in 245 while 243 had an anterior curve. This makes no difference with vertebral subluxation or its adjustment. Adaptative compensation IS different in these two.

Listing would be the same. but we would adjust MORE from inferior, on anterior, in 245 than we would in 243.

Illustrations 247 and 248.

Here (lateral view) is a typical flying wedge movement of atlas anterior and inferior. Some violent concussion of forces has been

delivered with sufficient violence to drive this atlas VERY MUCH anterior and inferior. Location of odontoid (lateral view) is posterior to magnum foramen; more than past center of atlas canal lumen from before backward. Serious pressure must exist in this case.

A-P view reveals nothing as serious as lateral portrays. Head, atlas, and axis are low on right. Listing would be AIR. To express it in evaluation would be: Atlas anterior double plus, inferior double plus, R.

Adjustment would require particular attention upon anterior and inferior; adjusting both VERY MUCH to opposite directions.

Illustrations 249 to 256 inclusive are atlas subluxations AIL.

Illustrations 249 and 250.

In all AIR or AIL atlas subluxations, abnormal positions of head as well as cervical portion of spinal column vary considerably. In positions of heads, they may be posterior, much posterior, or very much posterior. In cervical curves, they may be almost straight, slightly curved, much curved, or very much curved. All are adaptative compensations to torqued atlas subluxation.

In 249 (lateral view) cervical section is quite straight, leaning slightly forward, which throws head forward. If cervical spine had its normal curve, head would drop far more posterior than represented in this spinograph. In spite of these peculiarities, anterior arch of atlas is anterior of axis and anterior arch is inferior of normal relationship between occiput and axis. Posterior arch of atlas is superior of even anterior arch. This angularity of position throws odontoid process posterior into neural canal.

In 250, head, atlas, and axis are low on left, with cervical curve slightly compensatory to right.

Listing would be Atlas anterior inferior (lateral view) and inferior on left; therefore AIL.

Greatest evaluation in adjustment would be on atlas, left transverse, from anterior and inferior, raising head on left slightly. Each subluxation has a degree of direction characteristic of its own and must be adjusted accordingly.

Illustrations 251 and 252.

Atlas varies slightly from general rule laid down for 249, insofar as anterior arch does appear to be superior of posterior arch. If anterior arch alone is compared with posterior arch alone, of atlas, then this conclusion would be sound. Feature that reverses rule is that posterior arch is actually so superior that it is touching (if not actually contacting) occiput. That fact, in itself, throws this atlas into an anterior inferior.

In lateral view, there is no great, marked irregularity in relationship between axis and 3rd cervical. There is no crowding of spinous processes and little separation on anterior of centra. Note that odontoid process is leaning obliquely anterior and superior in neural canal, creating an interference at its posterior base in neural canal.

Adjustment on left transverse process, from anterior and inferior, would correct position of atlas posterior in its relation with odontoid of axis; in adjusting left transverse process from inferior, would correct it superiorly on posterior and bring posterior superior of posterior arch to inferior where it belongs. By raising left transverse process, you correct position of head and atlas from being low on that side.

Illustrations 253 and 254.

In some spinographic sets, there are complexing and confusing elements unless you figure what normal osteology should be, or was; and then what it isn't; and what abnormal movements placed it where it is now. When figured from that angle, you can always decipher, or solve position without difficulty.

Lateral view clearly shows anterior arch of atlas anterior. Anterior arch is inferior to posterior arch. In subsequent chapters we will get into question of plane lines to understand what we mean. General compensatory cervical curve is approximately straight, leaning forward, until we reach between axis and 3rd cervical where there is a break in contour. Axis is slightly posterior and inferior on its spinous process.

A-P view. Head, atlas, and axis are low on left. (In taking spinographs, get more of base of skull in than this spinographer took.)

Listing would be Atlas AIL, emphasizing and stressing more direction upon A and I than on raising head on left. The great objective is to get fovea dentalis back into odontoid process articulation.

Illustrations 255 and 256.

Direction of subluxation (lateral view) is similar to that of 253 except that 255 is worse. Lateral view shows anterior arch decidedly anterior. Also anterior arch is inferior of posterior arch. Reversing it, posterior arch is more superior than is anterior arch. Posterior arch is contacting occiput. Position of axis spinous process is about equal to that of 253, no more, no worse.

A-P view shows head, atlas, and axis low on left.

In 253, we mentioned to emphasize direction of A and I. In 255 we would emphasize it even more from the two same directions. There would be little raising of head on left. Odontoid is badly out of normal articulation in this case. Torque adjustment would be with nail point one on transverse process and reverse direction—AIL to PSR; with left hand nail hand, right hand hammer hand, with left elbow torqueing away from you or to superior.

(See Chapter on Adjusting and study in relation to each subluxation in this series.)

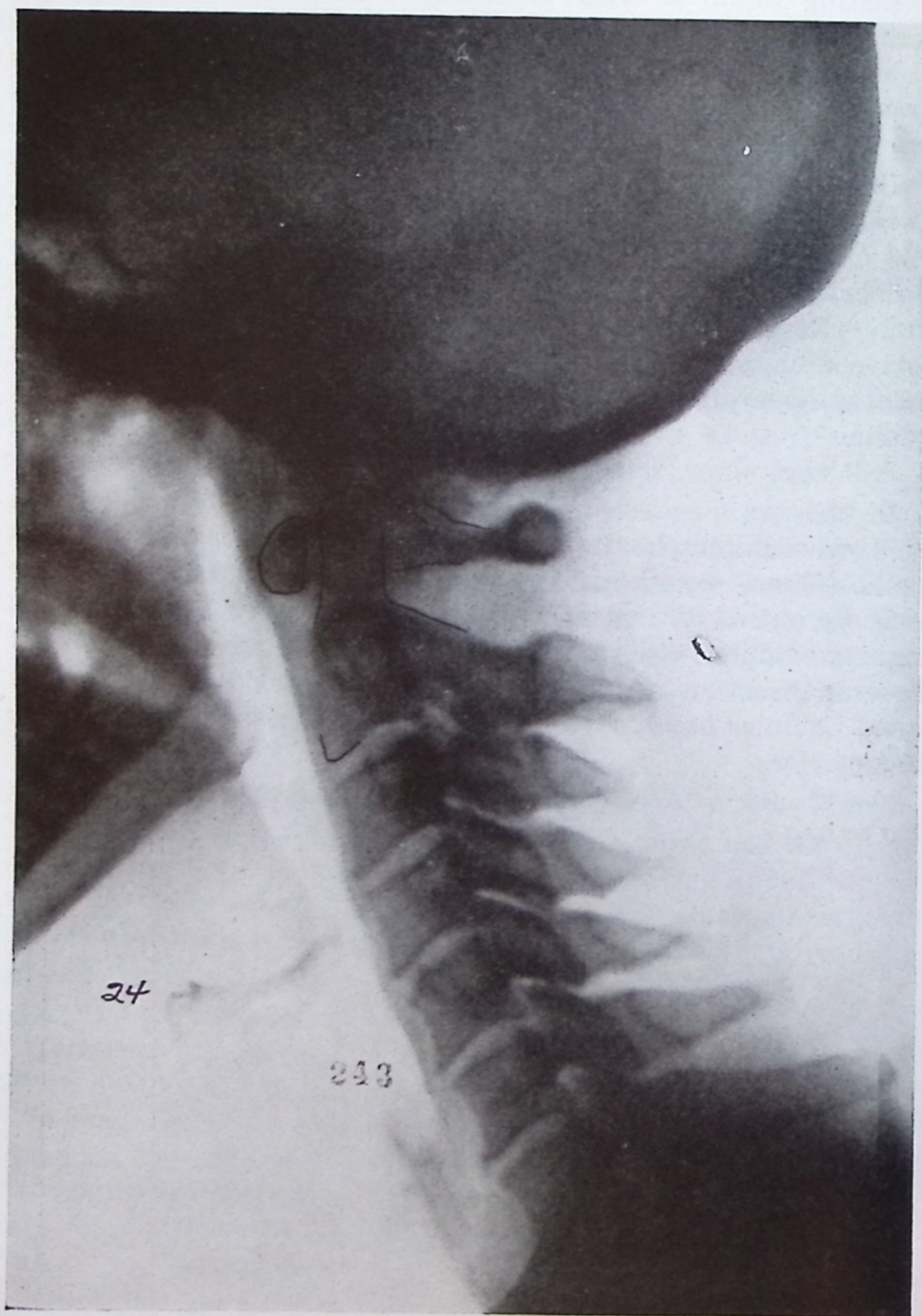


Illustration No. 243



Illustration No. 244



Illustration No. 245



Illustration No. 246

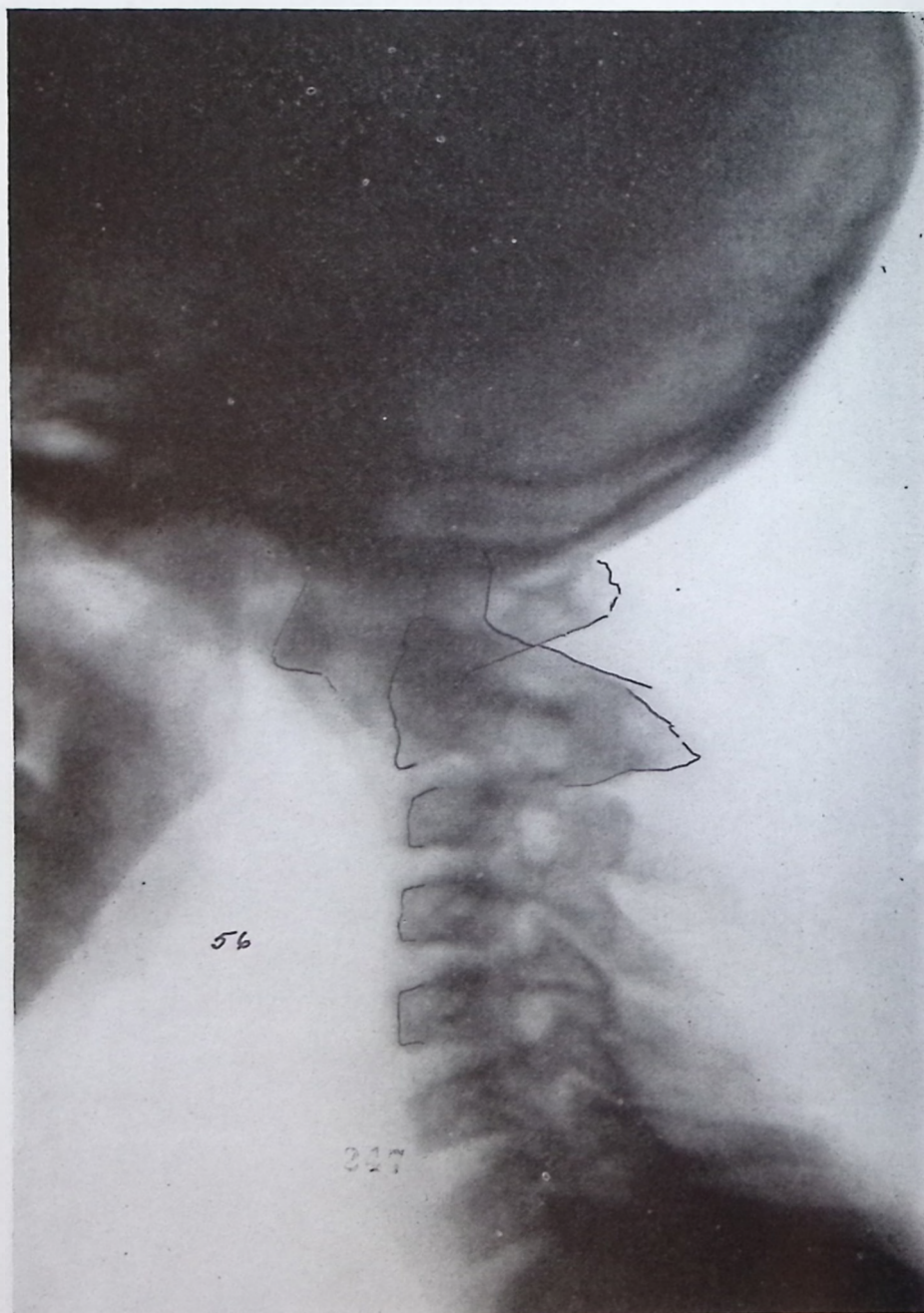


Illustration No. 217



Illustration No. 248



Illustration No. 249

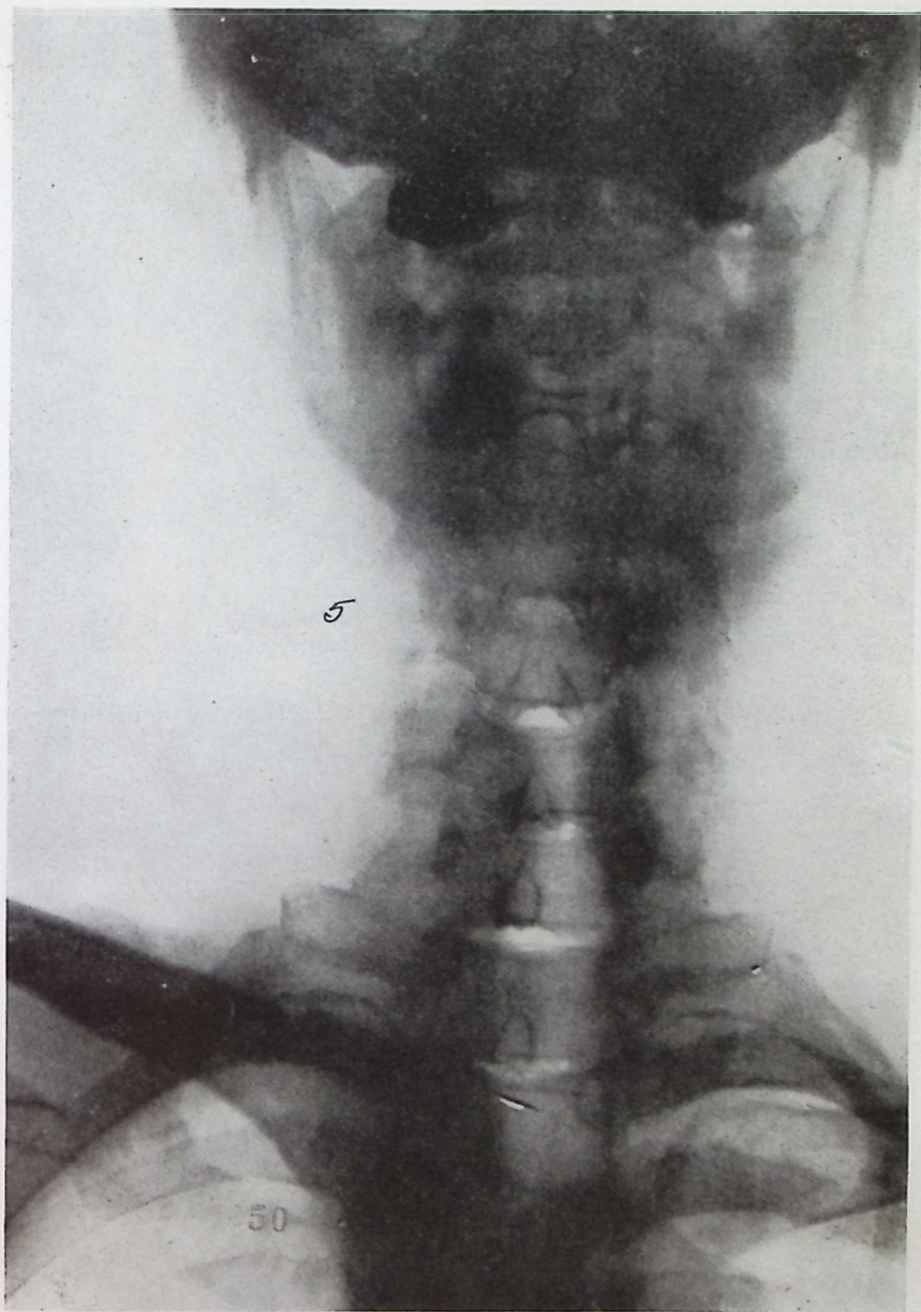


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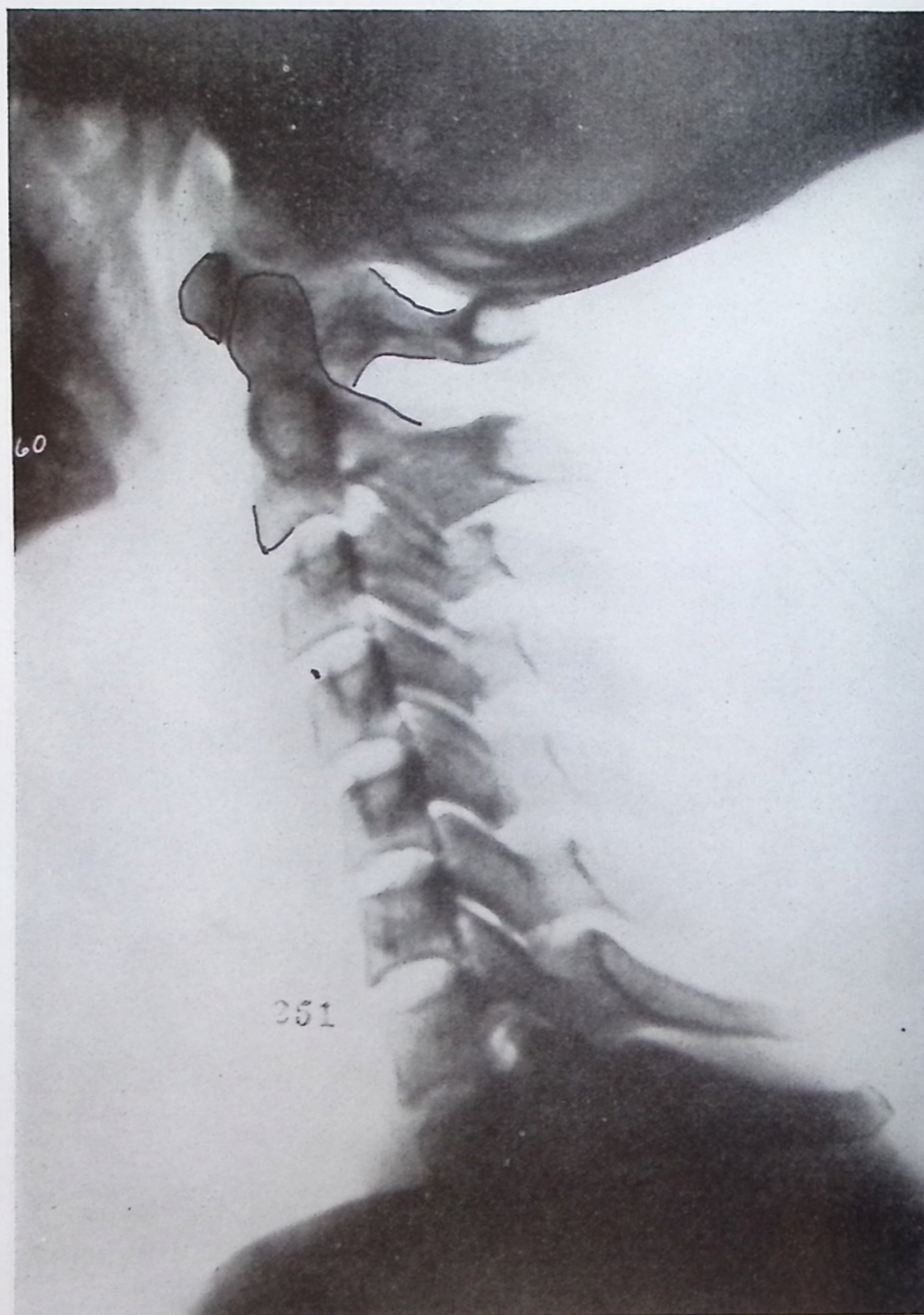


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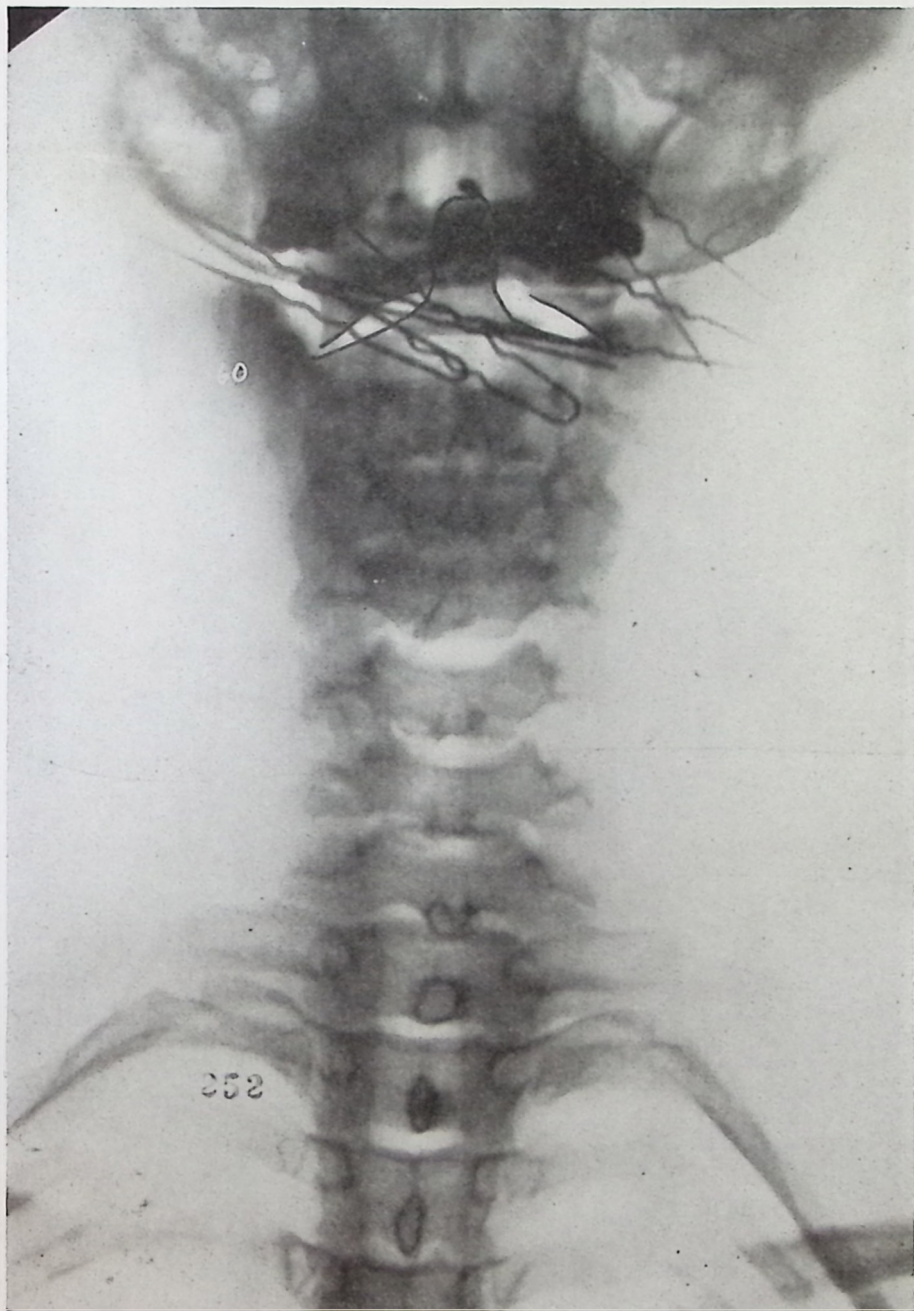


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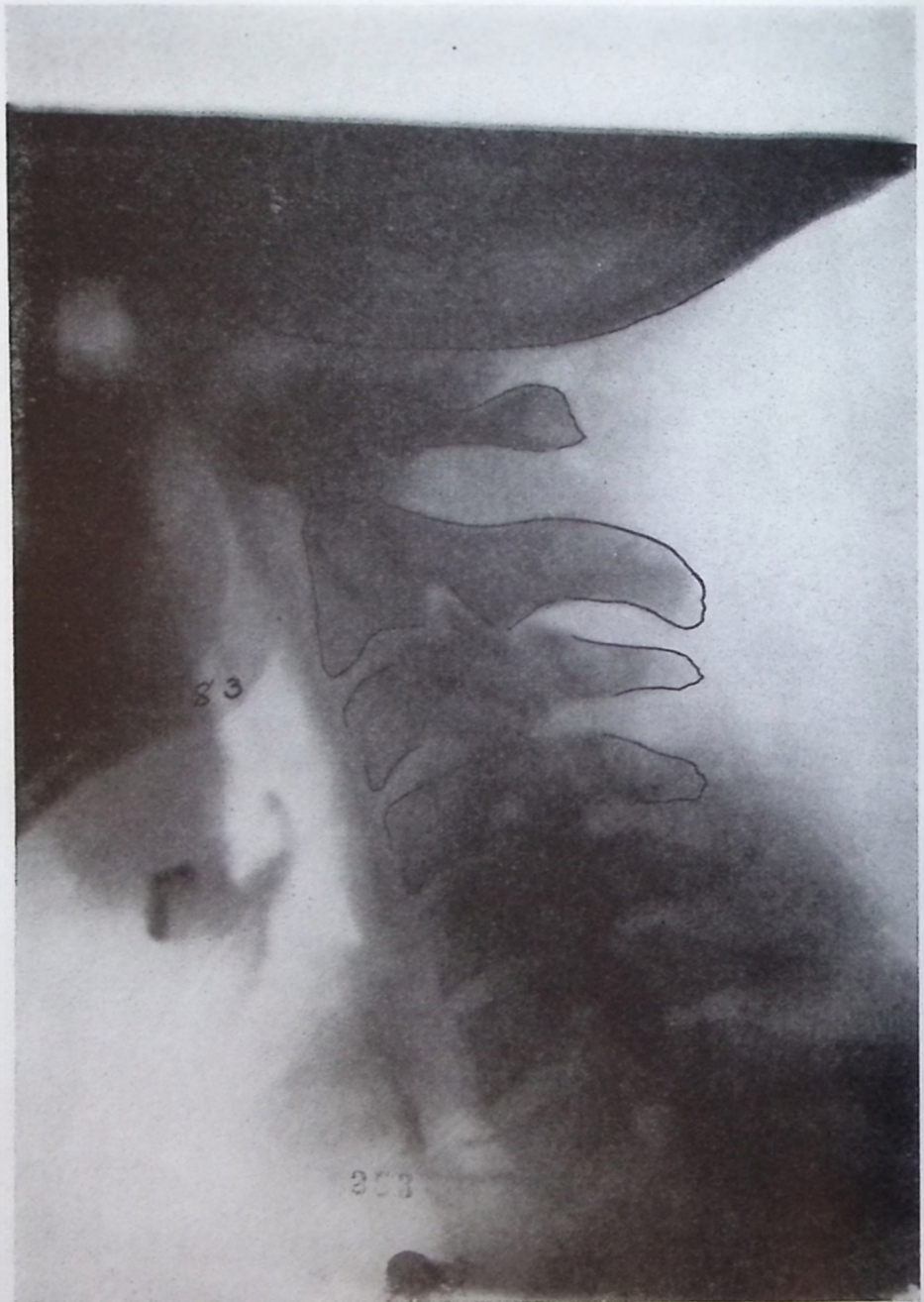


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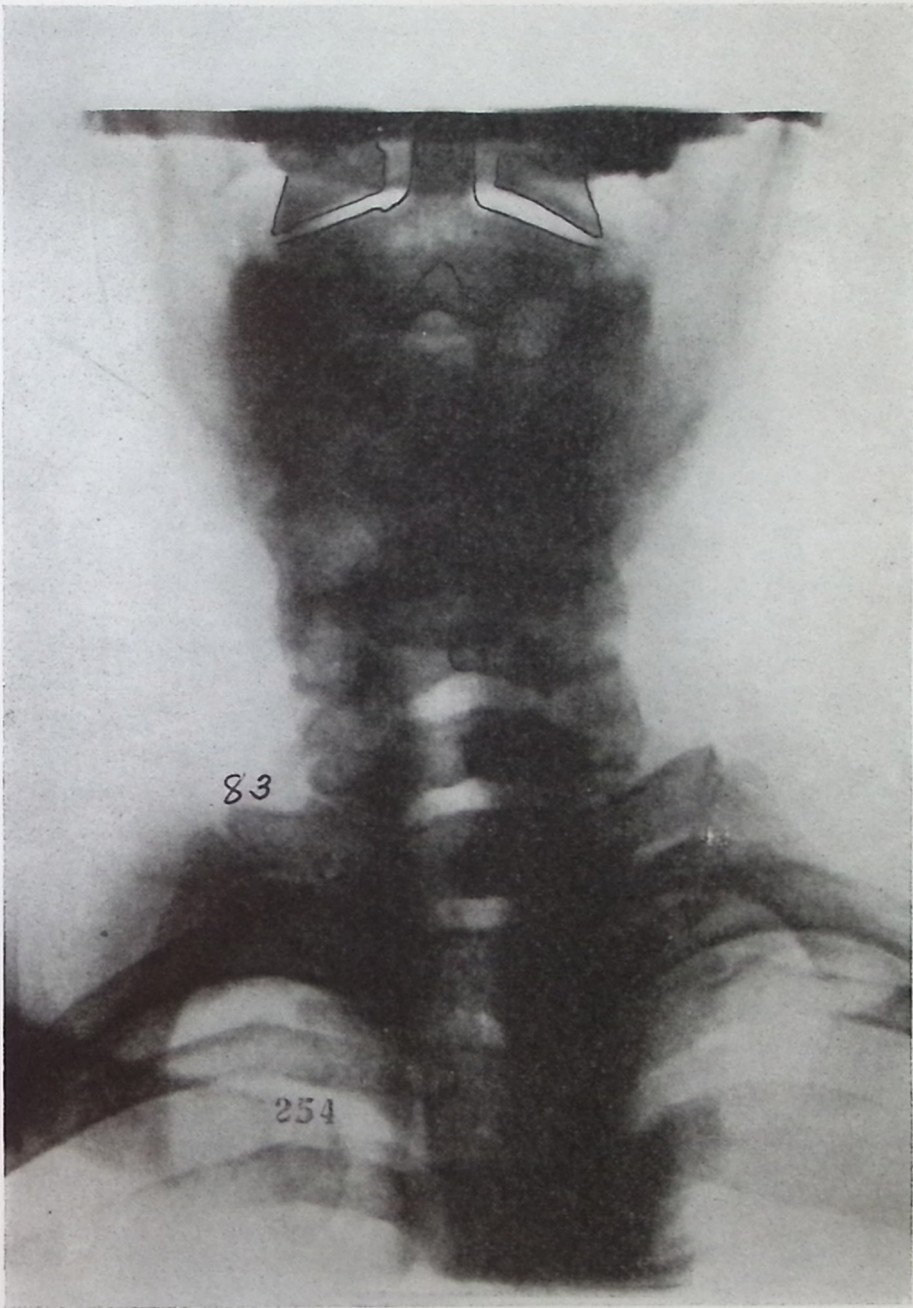


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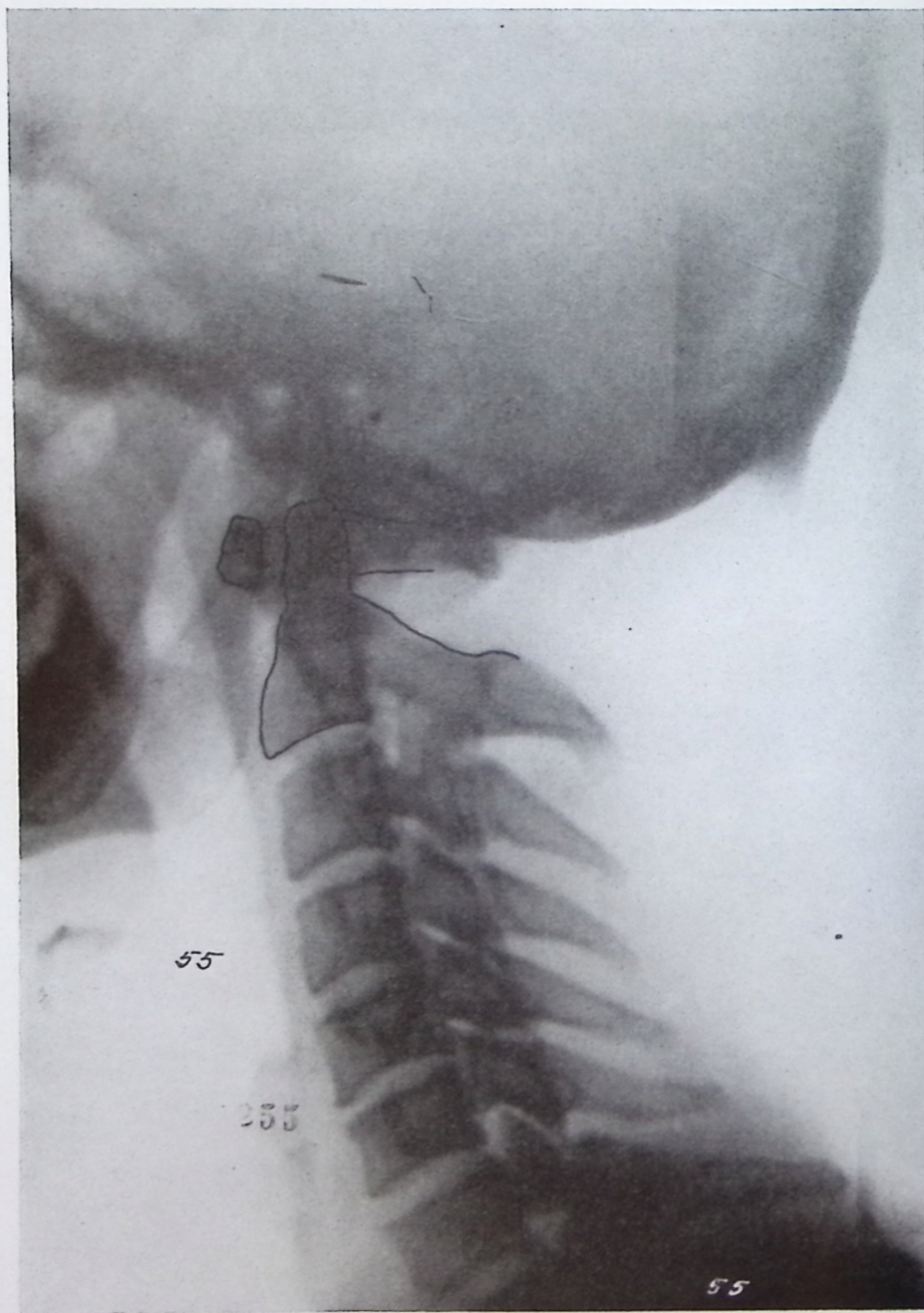


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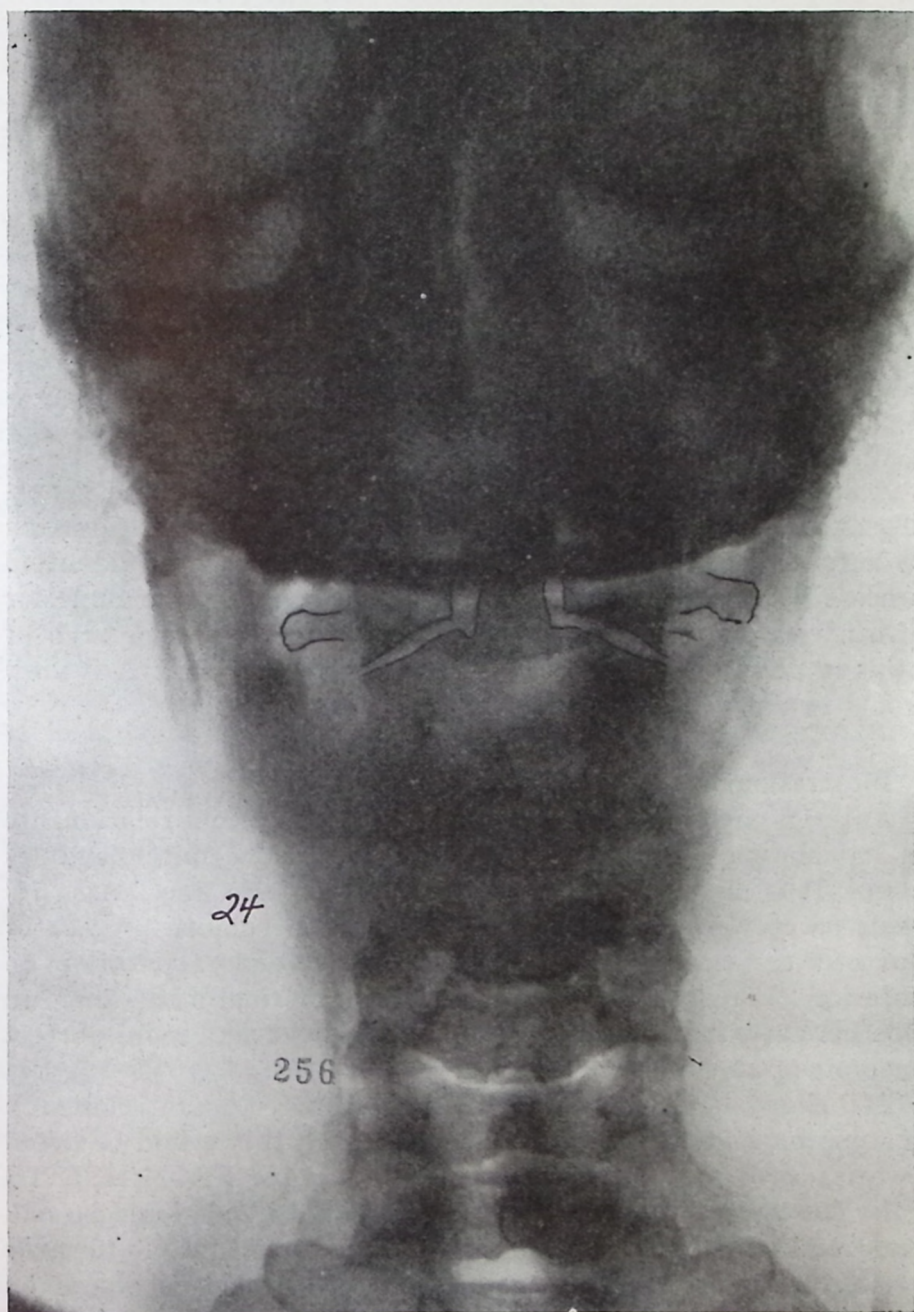


Illustration No. 256

CHAPTER XXVIII

ATLAS AS, L AND R SUBLUXATIONS



HERE is a variation in number of sets we reproduce in this book, on different directions of atlas or axis subluxations. This variation is no indication of frequency of any one kind. It represents number we gathered of each kind from our spinographic films.

Illustrations 257 to 272 inclusive are of Atlas Anterior, Superior, Left or Right.

Illustration No. 87.

A schematic pen and ink drawing to illustrate what is generally meant by an AS (anterior and superior) atlas. Anterior arch is anterior of normal relationship in articulation with odontoid process below and occipital condyles above. It is also Superior of a normal level plane line. Whether this AS anterior arch of atlas is superior on left or right, depends upon what A-P view would reveal.

Illustrations 88 and 89.

Anterior arch is anterior (lateral view) of normal relationship in articulation with odontoid process below and occipital condyles above. It is also superior of a normal level plane line. Axis reveals no crowding down upon posterior with spinous process of 3rd cervical vertebra. Neither is there forcible separation on anterior. Usually axis is somewhat off its normal plane line. In this instance, it is not, making atlas stand out as a more perfect example of an AS atlas.

A-P shows head, atlas, and axis low on left. As anterior arch is superior, and as head is superior on right, this would be listed as atlas ASR. Adjustment would be to torque FROM ASR TO PIL; downward; to posterior; to left. Right hand would be nail hand, left hand hammer hand; right elbow would torque towards you; left hand away from you. Emphasis would be placed on delivery from superior to inferior (lateral view); from right to left (A-P view).

Illustrations 90 and 91.

Anterior arch in lateral view is very similar to that of 88. Axis, on reverse, reveals a crowding down of axis spinous process somewhat upon 3rd cervical spinous process; not much, but some. There is a slight separation on anterior between centra.

A-P view shows head, atlas, and axis low on right. As anterior arch is superior (lateral view), and as head is superior on left (A-P view), this would be listed as atlas ASL. Adjustment would be to torque from ASL TO PIR; downward to posterior; to right. Left hand nail hand, right hand hammer hand; left elbow towards you, right hand away from you. Emphasis would be placed on delivery from superior to inferior (lateral view); from left to right (A-P view). A to P; S to I, and lowering of head on left would all three have about same degree. All three would need accentuation.

Illustrations 257 and 258.

In lateral view, cervical section is almost straight, leaning slightly forward. This is compensatory to torque subluxation of atlas. Atlas anterior and superior has thrown head backwards. As head leans backward, cervical leans forward to compensate.

Lateral view shows atlas wedged (if we may use that term) anterior and superior off of normal articulation with occiput out of normal articulation with odontoid. Condyles of occiput are posterior of normal location, as is odontoid process of axis, both of which positions force atlas anterior and superior.

Anterior arch of atlas is anterior and superior of plane line to posterior arch of atlas.

A-P view shows head, atlas, and axis low on left, raising head superior on right. Note compensatory adaptative cervical curve to right because of head low on left; or because of head high on right.

Illustrations 259 and 260.

Lateral view shows atlas in similar position as in 257. Axis shows spinous process more inferior on spinous process; more forcible separation on anterior of centra than in 212.

A-P view shows head low on left, or high on right. As atlas

is anterior and superior (lateral view) and as head is superior on right (A-P view), then this would be atlas ASR.

In 257 (lateral view) odontoid process points obliquely superior and anterior. In 259 (lateral view) odontoid process points obliquely superior and posterior. In 257 actual pressure-interference is at posterior base of odontoid upon spinal cord. In 259 actual pressure-interference is at posterior tip of odontoid upon spinal cord. Notwithstanding both are ASR atlas torqued subluxations, yet they present different positions of odontoid. This will run consistently thruout any one series of same direction of subluxation, but it does prove necessity for more care in evaluation of direction of adjustment to correct position of odontoid to replace it into fovea dentalis.

Illustrations 261 and 262.

Lateral view is very similar to that of 259 subluxated to same direction and in same degree. Location of odontoid of 261 is same as 259. Axis spinous process is more inferior, and forcible separation on anterior of centra is more marked than in 259. Direction of adjustment would be same with more emphasis on inferiority in 261 than in 259.

Illustrations 263 and 264.

Conditions in 263-264 are similar in general nature to those of 259-260; 261-262.

Illustrations 265 and 266.

Lateral view shows a more marked adaptative compensatory anterior cervical curve than in any other set in this group. It is in marked contrast to Illustration 257. Atlas AS in this group throws head backward and downward, which is compensated for by cervical being thrown forward. As head is thrown backward, it forces axis spinous process inferior on 3rd cervical spinous process. This artificial compensatory cervical curve and position of head would be corrected when atlas is correctly adjusted to normal position.

A-P shows head, atlas, and axis low on left or high on right. Listing therefore would be ASR because superior side is right

side. Adjustment would be given on R transverse process of atlas.

Illustrations 267 and 268.

Lateral view is characteristic of all AS subluxations of atlas. Odontoid process is characteristically pointing obliquely superior to anterior. Actual pressure-interference would be at posterior base of odontoid process.

Head is adaptatively thrown posterior and inferior to where condyles are resting on posterior portion of superior two-thirds of its normal articulations. Adjustment of atlas would correct position of head. Notice slight adaptative cervical curve more noticeable at base of cervical section.

A-P view. Head, atlas, and axis low on right; or high on left. This would make listing AS (lateral view) and L (A-P view). Adjustment would be given on L transverse process of atlas. See rules for adjusting in another Chapter and familiarize yourself thoroly with that work.

Illustrations 269 and 270.

Lateral view is as usual of all AS subluxations of atlas. Odontoid process, however, in 269, while pointing obliquely superior and anterior, yet it is more posterior in its entire position than in 267, creating an open gap-space between anterior of odontoid and posterior of anterior arch of atlas. Head in 269 is more posterior and inferior than in 267 without usual compensatory adaptative cervical curve forward as is noticeable in 265.

A-P view. A word of caution. All hair-pins and other metallic substances should be removed before taking spinographs. They destroy positive values of shadows for study. (This spinograph was not taken at the PSC Spinographic Laboratories). Head, atlas, and axis are low on right, or high on left.

Listing therefore would be AS (lateral view) and L (A-P view).

Illustrations 271 and 272.

Lateral view same as in previous AS atlas subluxations. Odon-

toid is even more marked in general posterior position than in 269. Compare to see this difference. Slightly more cervical adaptative curve.

A-P view. Head, atlas, and axis are low on right; or high on left.

Listing would be AS (lateral view) and L (A-P view).

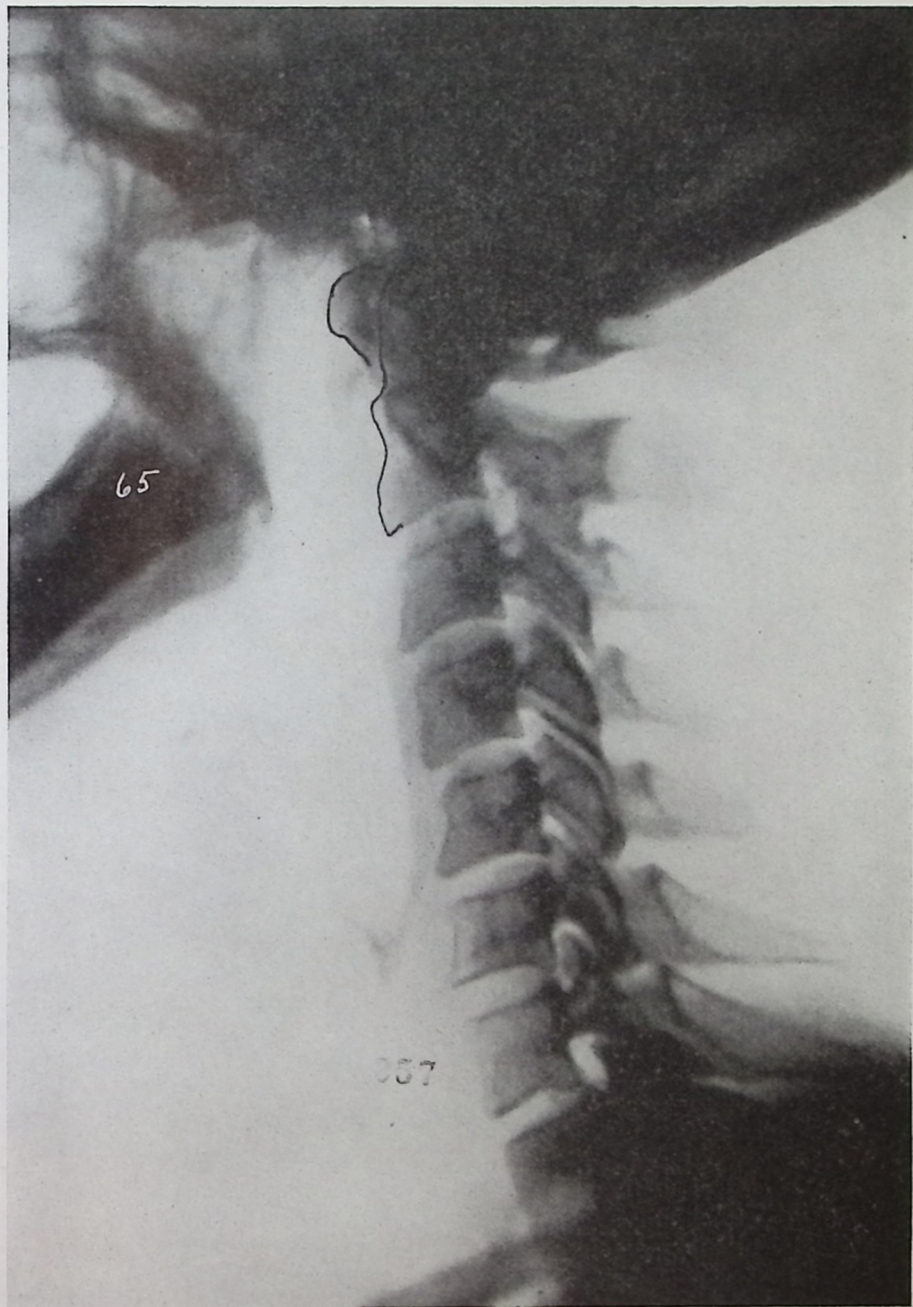


Illustration No. 257



Illustration No. 258

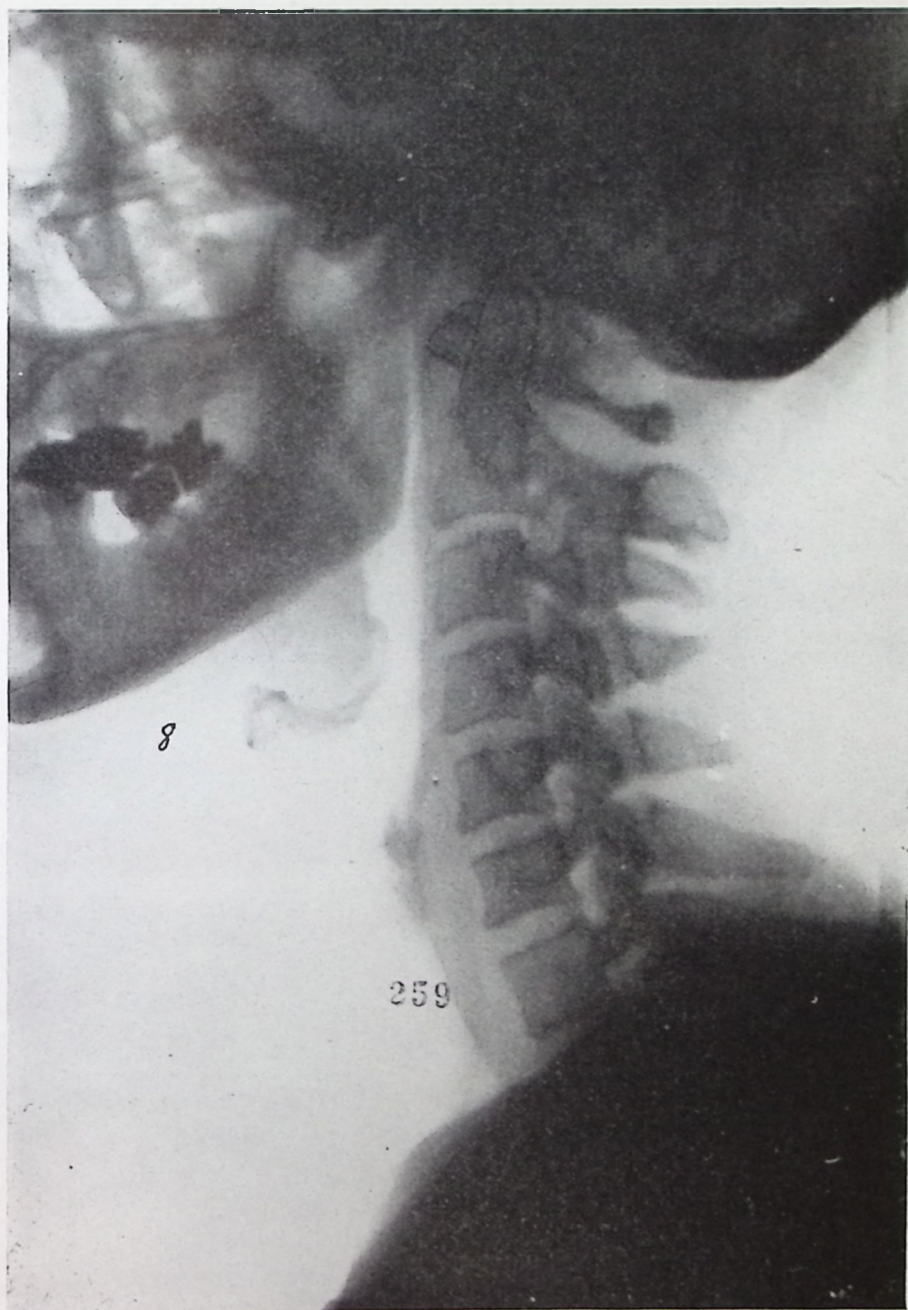


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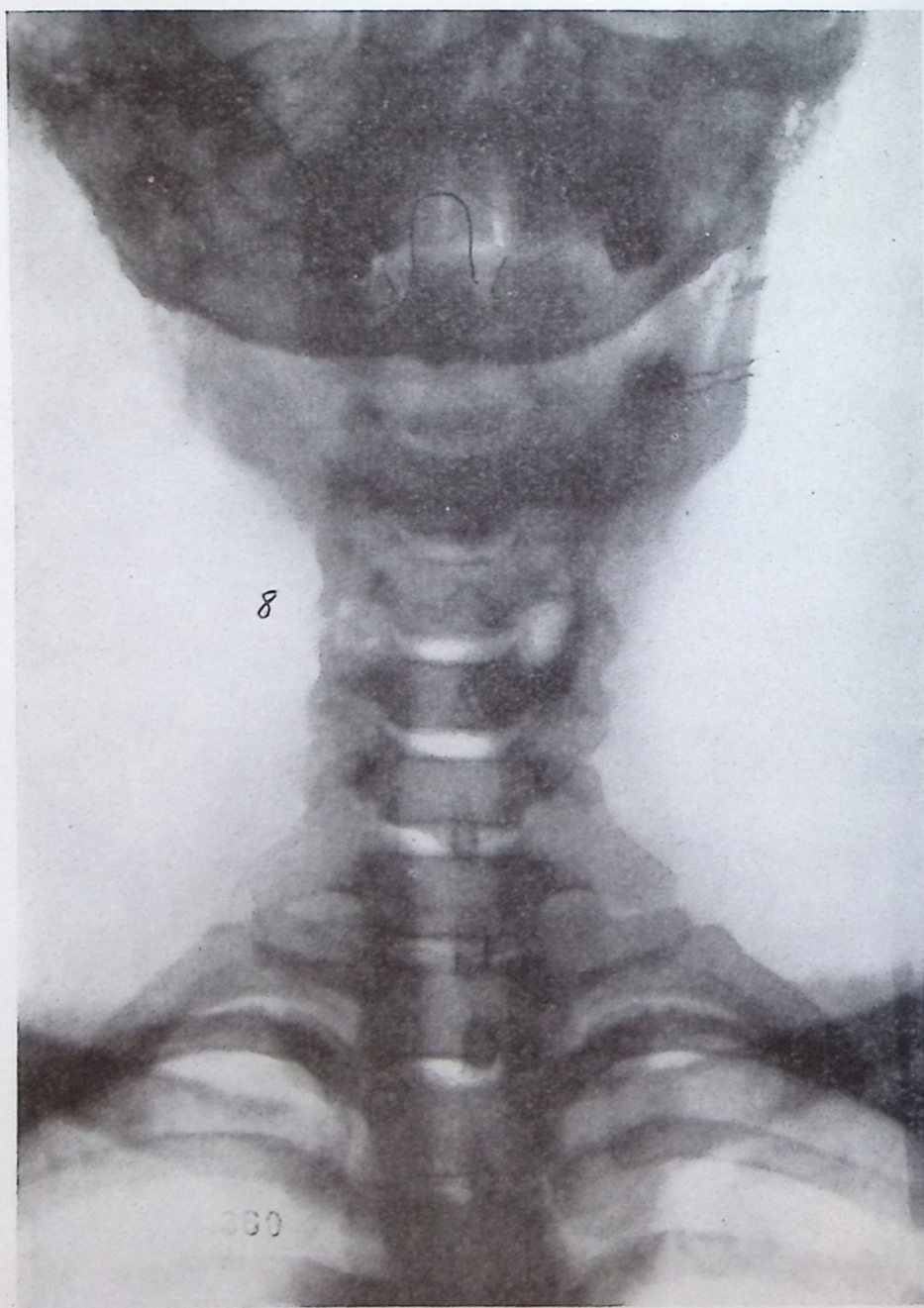


Illustration No. 260



Illustration No. 261

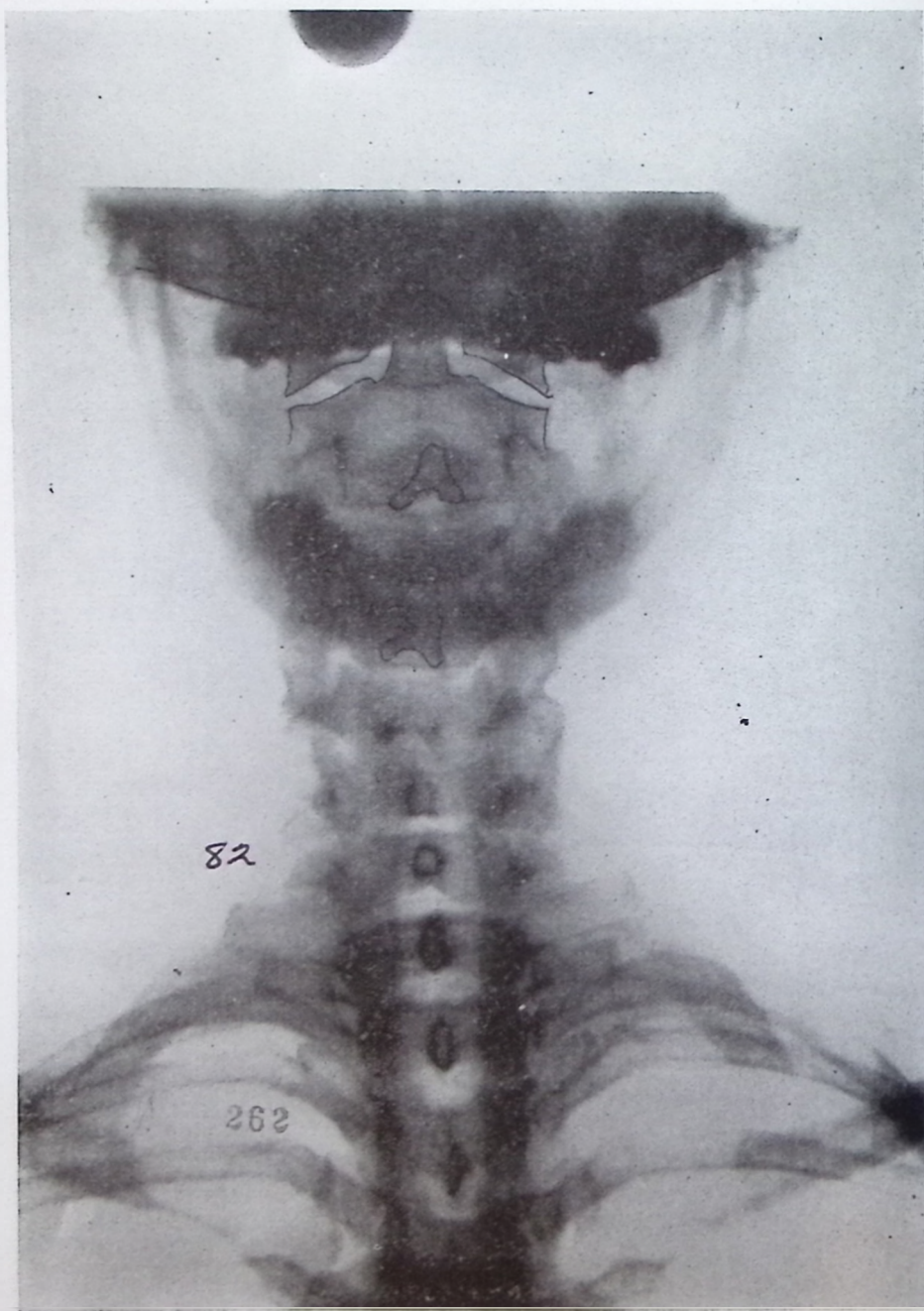


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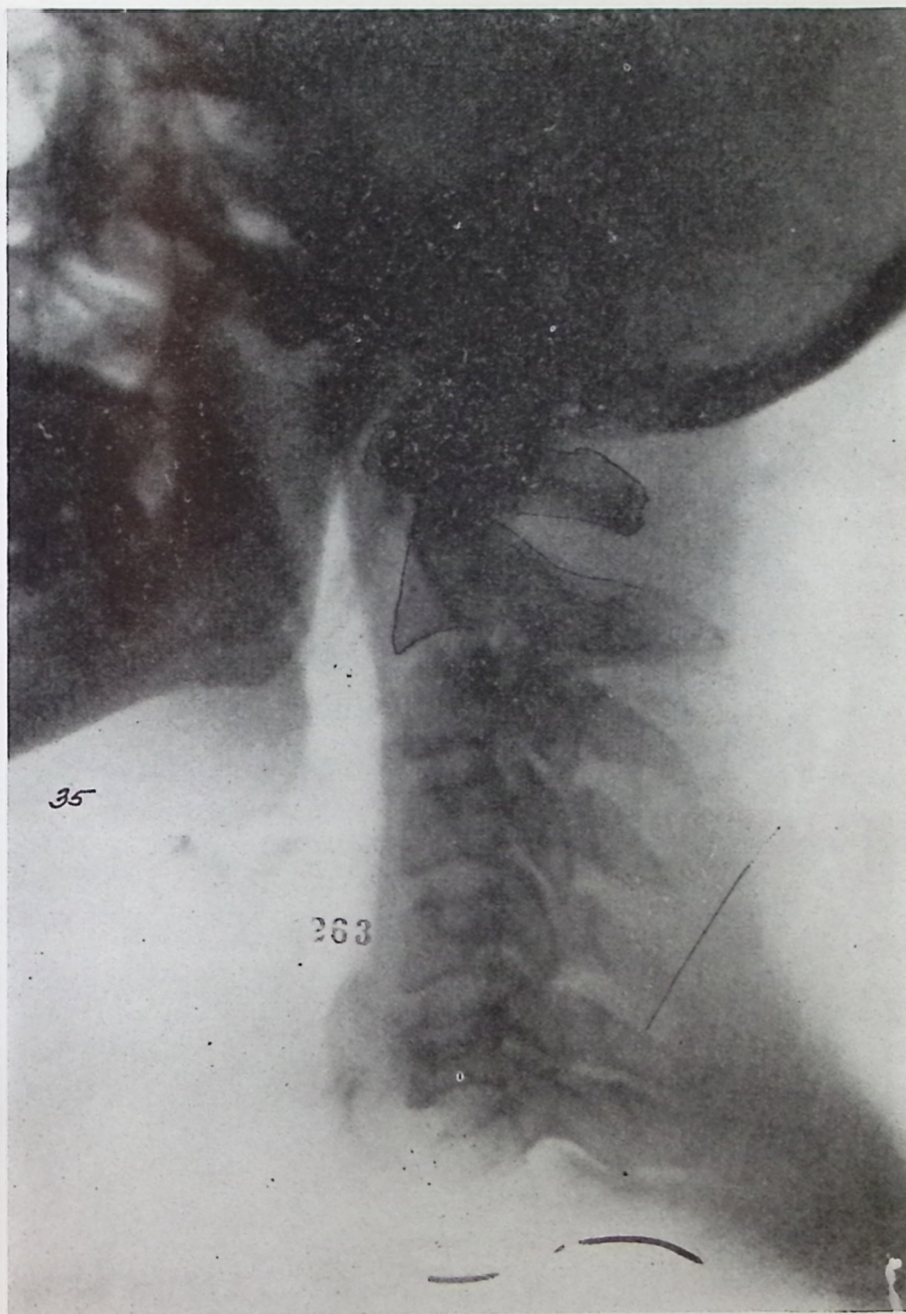


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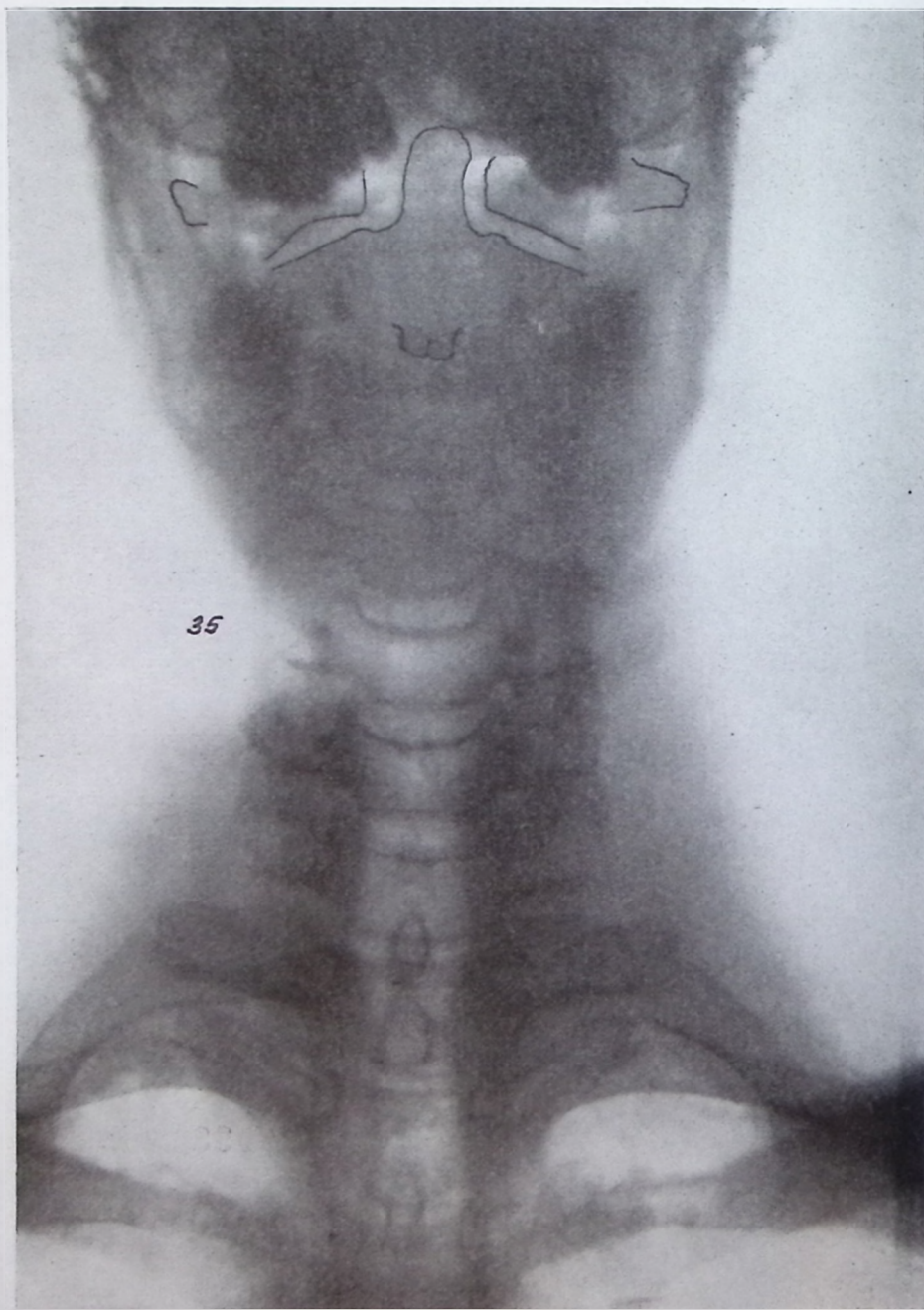


Illustration No. 264



Illustration No. 265

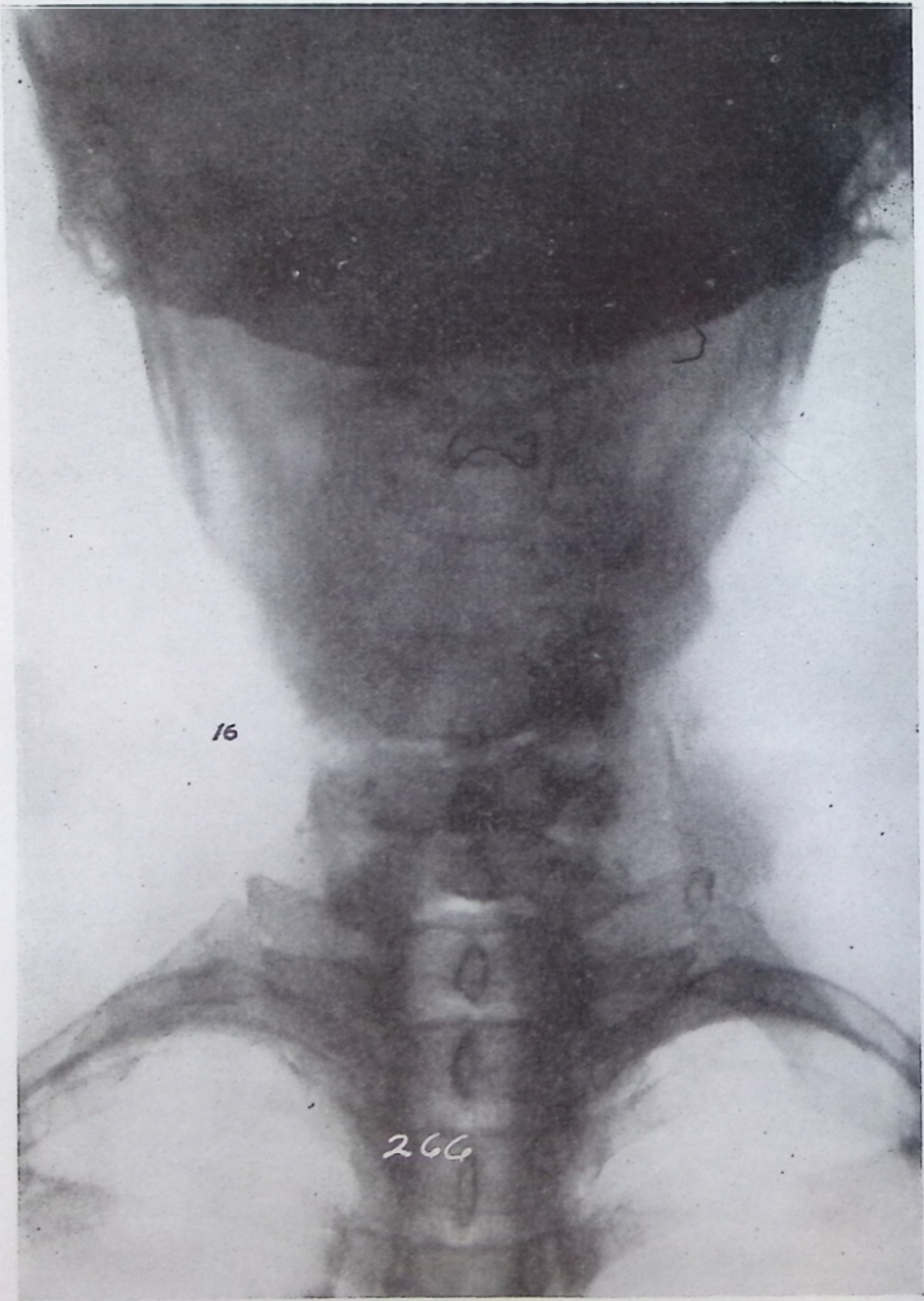


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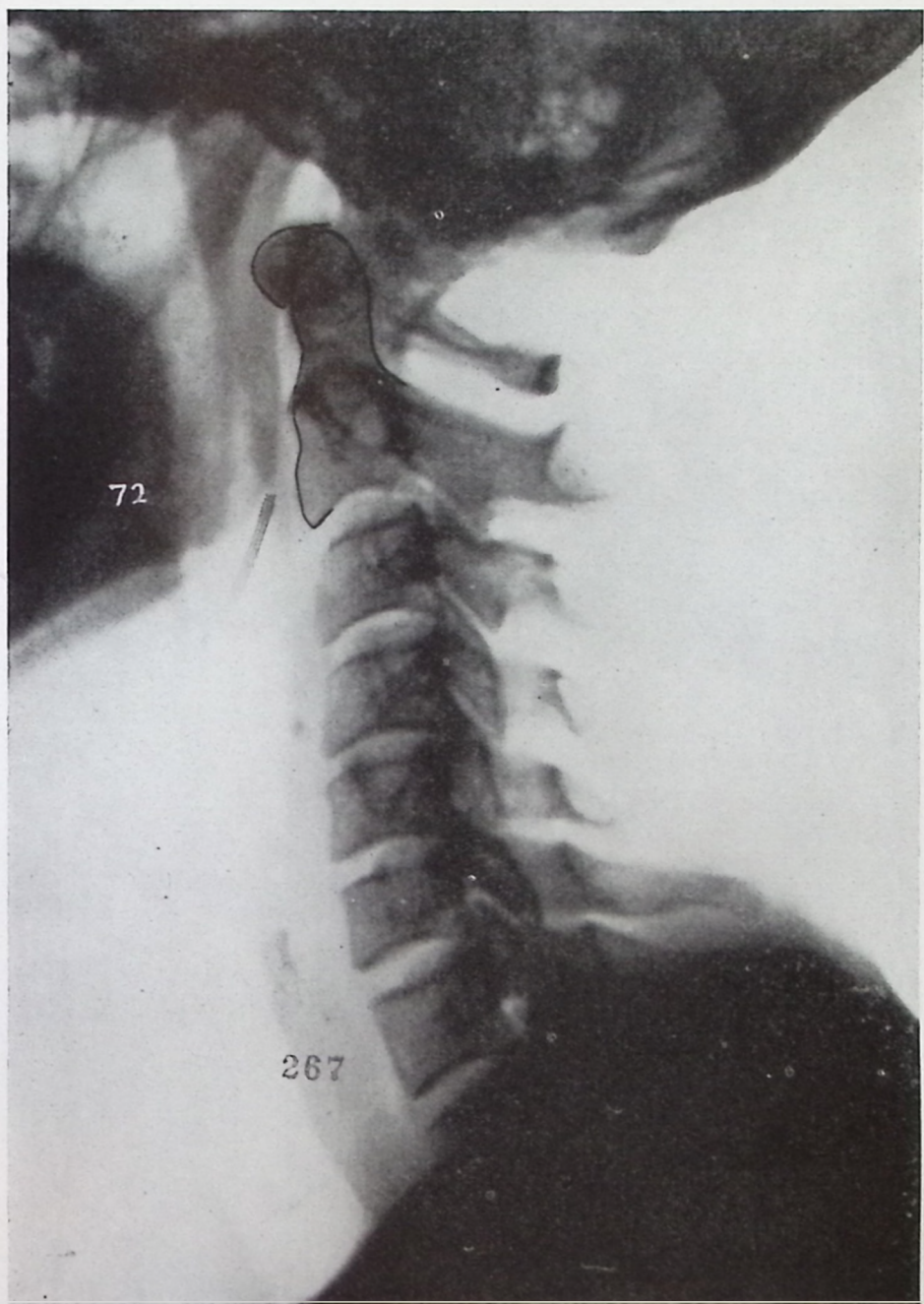


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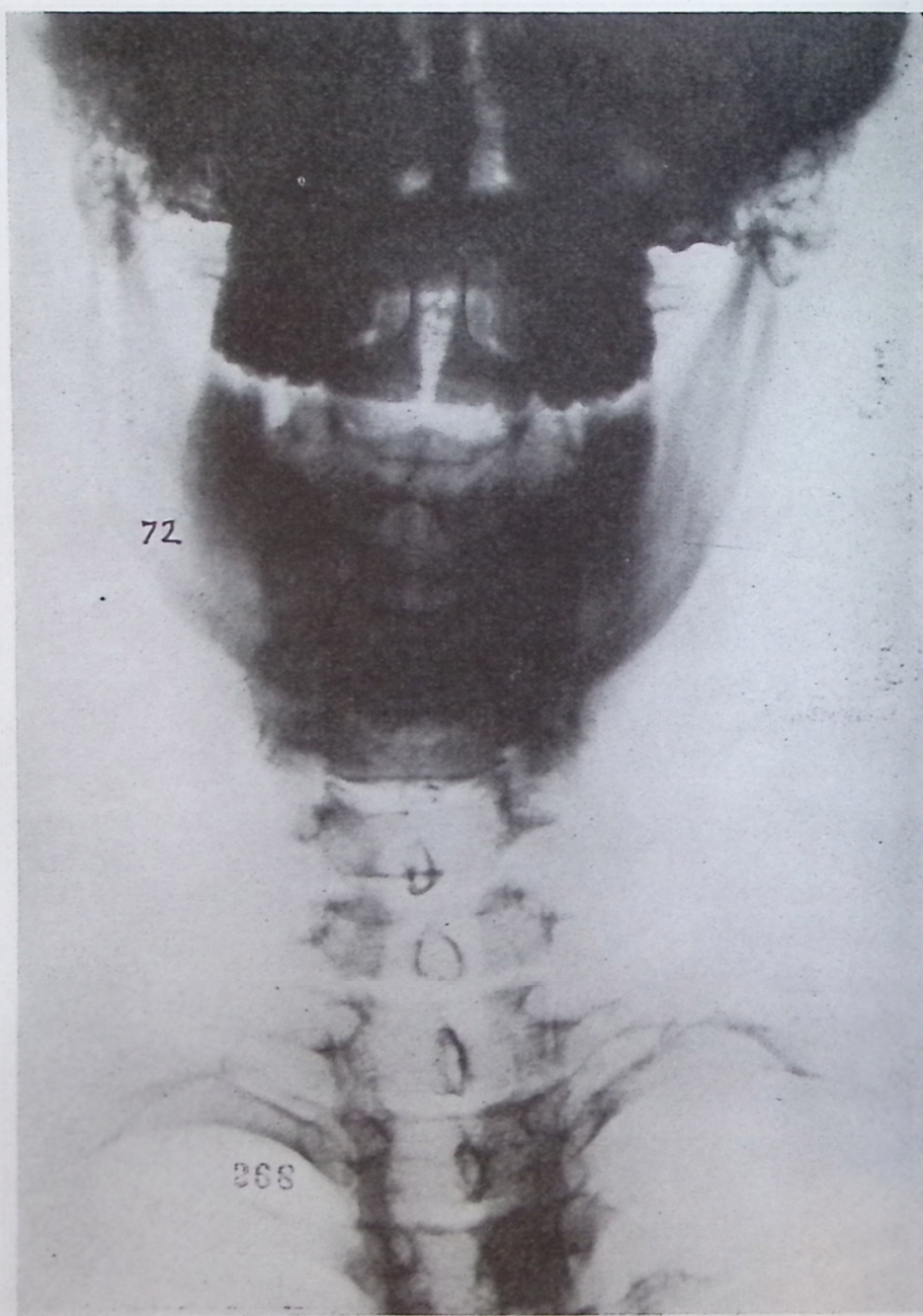


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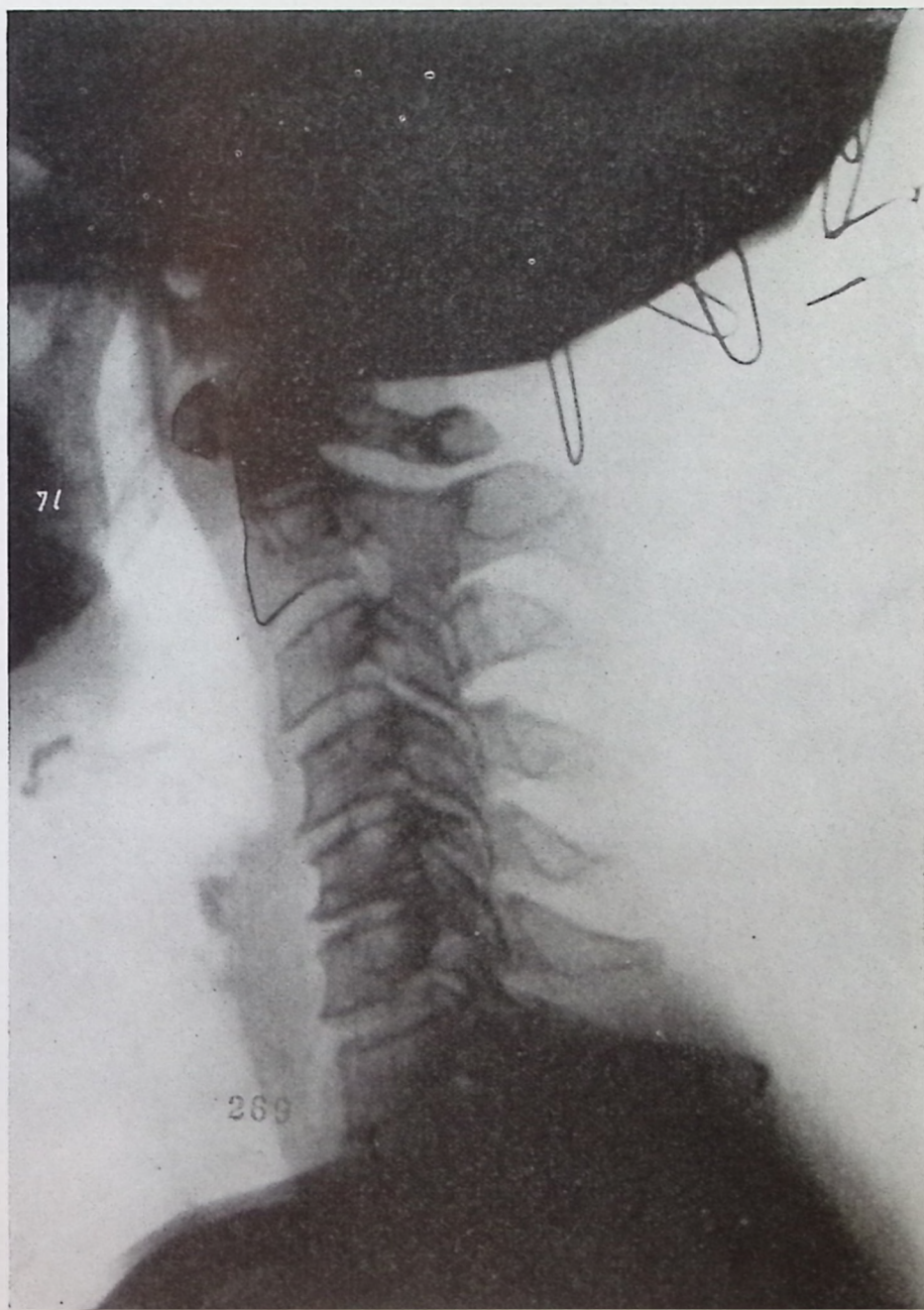


Illustration No. 269

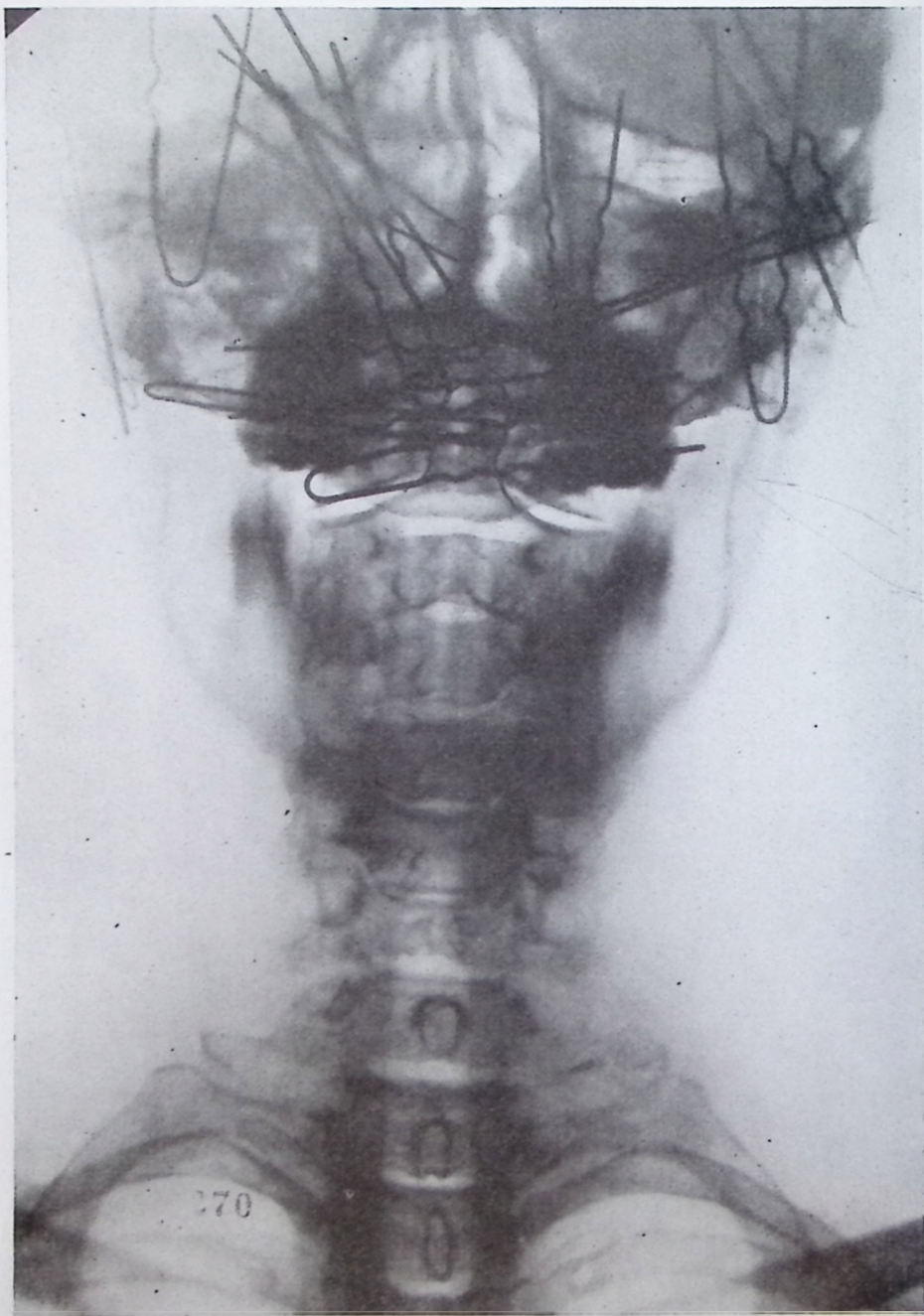


Illustration No. 270



Illustration No. 271

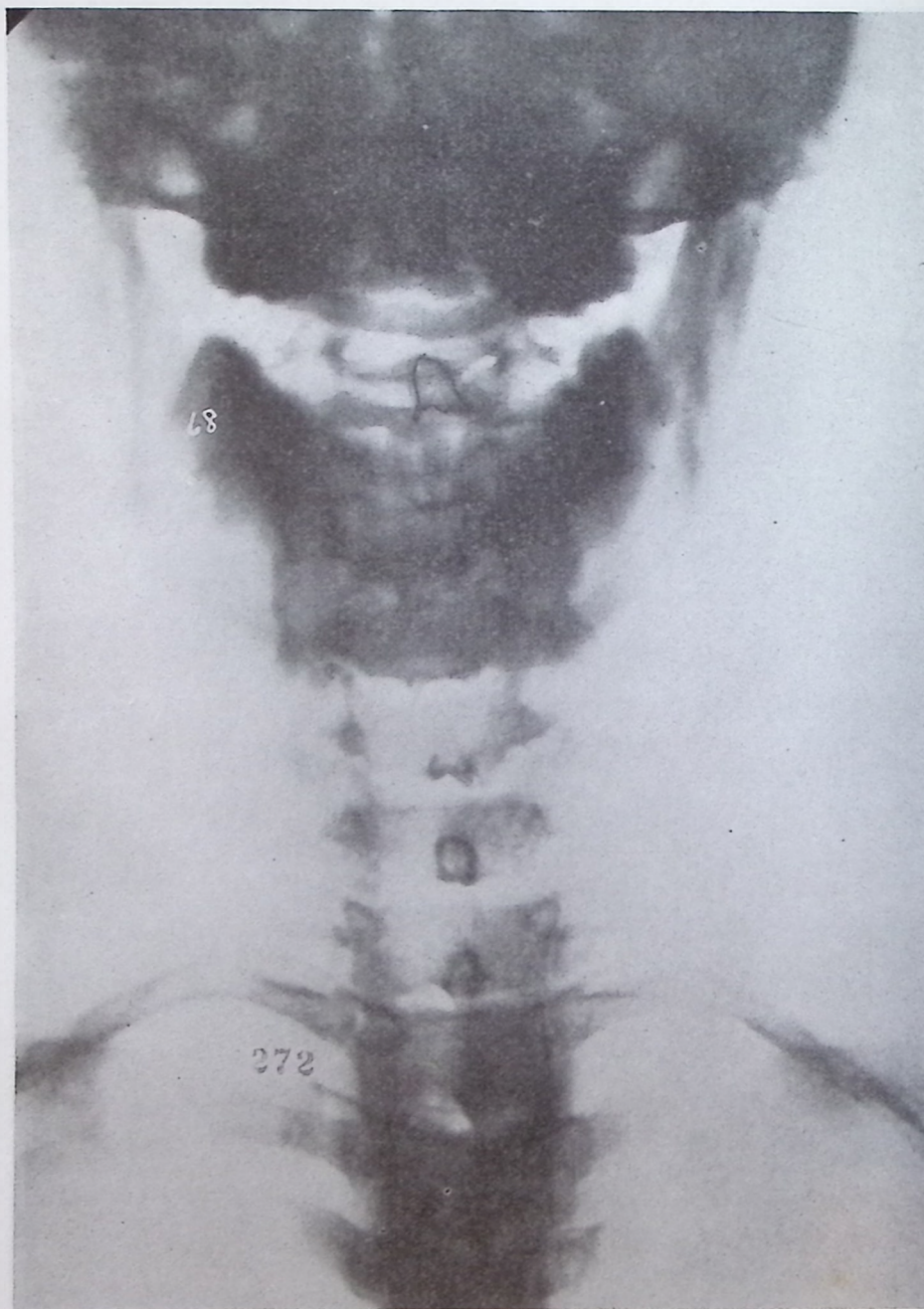


Illustration No. 272

CHAPTER XXIX

PLANE LINES



UNDER "definitions" in beginning of this book, we have defined these terms. We suggest you go back, read it, understand it, know it now before studying actual spinographs on which we have drawn plane lines. Many people have no "plane-line" mind. Some people can approximate weights by looking at an object; others may be off, many pounds. Some can look at a line and tell whether it is level; others would be off, feet. Some people can measure heights and lengths quite accurately; others would be off, yards. It may be a "gift", but it's nice to have it when reading spinographs. In the absence of this ability, draw them as we have.

We suggest now, before starting a study of these spinographic studies and their plane lines, you refer back to Illustrations 6, 7, 8, and 9. Get fixed in mind normal position of atlas and axis in relation to each other; what normal plane lines would be, in relation to each other; and how they ought to be in spinal column both anterior-posterior and lateral.

In all sets of two spinographs, of an A-P and lateral axis or lateral and A-P atlas, we have drawn a lower level plane line and a perpendicular plumb line on one side.

It is remembered that spinographs are taken correctly by properly placing the body! Then films run true to all level and plumb lines. That subject is covered in another part of this book and will not be repeated here.

AXIS SUBLUXATIONS

A-P view.

The following lines are observable:

1. A level line, at bottom of picture.
2. A plumb line running perpendicularly based on center tip of odontoid process.
3. An unlevel line thru occiput, showing how much and which way it is off level, by comparison with level line.
4. An unlevel line run thru atlas from center of one transverse process to other, thus showing which side is low, or high.

5. An unlevel line passing thru either body of axis or from superior rims of left and right pre-zygapophyses.
6. An off plumb line from superior tip of odontoid process of axis down to and thru center of spinous process of axis, to show whether it is left or right of median plumb line. This line will be noted as varying in position when the subluxation is PLI or PRI. It reverses sides.
7. Wherever it is apparent sufficiently to justify, we have drawn a curved lateral line to show cervical compensatory line; as whether head is low on right, curve should be left (altho it not always is); or if head is low on left, curve should be right (altho it not always is).

Lateral view.

1. A level line, at bottom of picture.
2. A plumb line, running perpendicularly, usually to anterior of cervical spinal column so as not to interfere with any other line we might draw. This line is there only for comparison.
3. An unlevel line across base of occiput to show how much it may be off level.
4. At right angles to that unlevel occiput line, is another. Right angle line shows how much head is off balance as it sits on condyles.
5. An unlevel line thru atlas, from center of anterior arch to center of posterior arch. This shows which way atlas may be tipping, superior or inferior, in relation with occiput or axis.
6. An unlevel line thru axis, from center of anterior of body to center of axis spinous process. By comparison with other lines superior inferior, it will prove torque of axis, if such there be.
7. An off-plumb perpendicular line from tip of apex of odontoid process downward thru center of body from above downward. A comparison of all lines, so far, reveals comparative positions of occiput, atlas, and axis.
8. Individual lines are drawn thru centra of several inferior cervical vertebrae, from center of anterior of centra to center of posterior of centra.
9. Individual lines are drawn at right angles to each of these

(8) for purposes of showing how much vertebrae differ in their correct relationship to each other and thus prove adaptative curves to untorque subluxations of atlas or axis.

ATLAS SUBLUXATIONS

A-P and Lateral views will in no way differ, so far as locations and directions of lines are concerned. Conclusions to be interpreted from each other will materially differ, however.

1st. A horizontal line between jugular process tips, from one side to other. Sometimes jugular tips are long and extend from superior to inferior; sometimes hardly observable; sometimes not even seen, altho latter condition is rare. When not observable in even small form, an imaginary true horizontal occipital plane line can be drawn to act as a base.

2nd. Outer inferior tips of lateral masses of atlas, regardless of location. Draw plane line between, breaking it immediately at their tips, extending it beyond to a point immediately inferior to jugular process tip superior. Doing this on both sides gives a comparative line with No. 1. If side-slip is marked, these two lines will converge on one lateral side and separate on other, thus marking POINT of wedge as well as BLUNT end of wedge.

3rd. Sometimes inner inferior tips of lateral masses of atlas, regardless of location, are more plainly observable than outer inferior tips. If they are, draw plane line between, break it from there out, extending it to a point immediately inferior to jugular process tip superior to it. Doing this on both sides gives a comparative line with No. 1. If side-slip is marked, these two lines will converge on one lateral side and separate on other, thus marking POINT of wedge as well as BLUNT end.

4th. Two perpendicular lines from the lower plane line, TO superior plane line, BETWEEN jugular process tip inferior. By comparison, if side-slip is apparent, two lines should be of unequal length; one side shorter. This difference in length is difference in side-slip of atlas high on one side and occiput appears low on same side.

5th. Transverse processes are not a sound guide, varying in normal or abnormal uniformity; but if other guiding location points are invisible, indistinct, or uncertain, then to outline in-

ferior borders will give comparative differences in one lateral portion of atlas being more superior, other side more inferior, thus gauging distances with occiput above; one side being closer than other.

6th. Sometimes, altho rarely, condyles of occiput show superior to atlas. When they do, they should be distinctly outlined. When outlined, one condyle will appear low on one side, high on other, determining and proving atlas in OPPOSITE direction in wedge-side-slip.

7th. Occasionally, altho rarely, inferior articulations of atlas will side-slip off of and to left or right of superior articulations of axis further proving wedge-side-slip of atlas. When such does exist, it is strong evidence that axis appears subluxated as well as atlas; altho in reality it is adaptative to atlas side-slip.

CONCLUSION

Glancing thru this Chapter and comparing one set of two views of any one case with two views of each other case, may seem like a needless and useless duplication of observation and study. I assure you I would not waste time if such WERE true. It was THIS line of observation that first focused my researching attention to THE SPECIFIC SUBLUXATION. When human life is at stake, any duplication justifies IF by so doing it brings a different character of degree of evaluation of directions, from which a different and understanding adjustment can be intelligently gleaned, and thus step up our efficiency. It is by use of such lines that my mind's eye ALWAYS determines it major. At first I drew lines. Now those lines are so firmly understood and fixed that I no longer find them necessary.

We suggest that students of this work take each set of two spinographs of each case; draw these lines on films or prints if necessary; go slow; study carefully; pass on to another set; study that carefully; turn back, and compare one ahead with one behind; two ahead with two behind, etc., just as we have done in these pages. COMPARISON is the greatest teacher we have in understanding torque work leading to torque adjustment.

CHAPTER XXX.

AXIS PLI TRUE SUBLUXATION PLANE LINES.

Illustrations No. 283 to No. 314

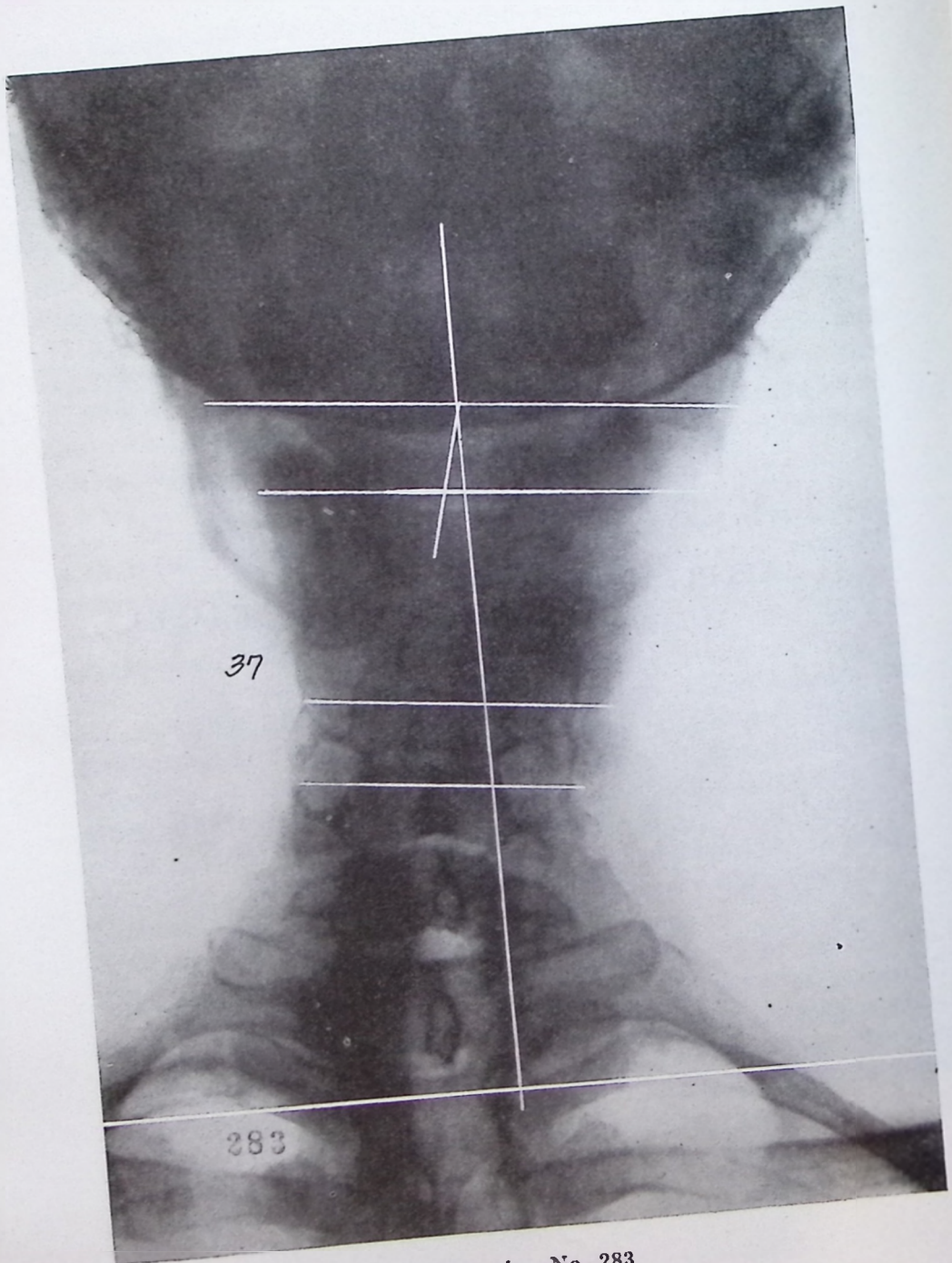


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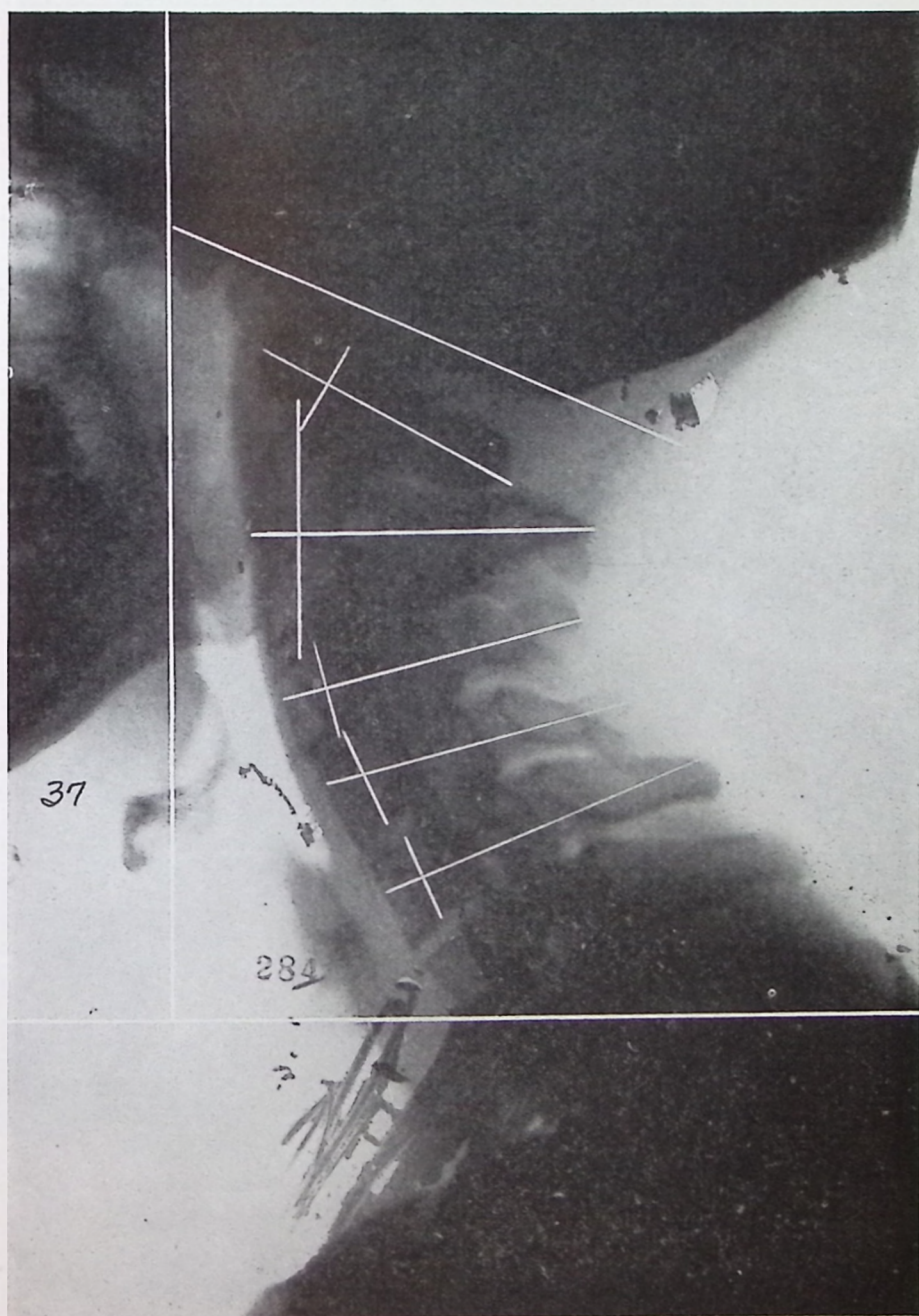


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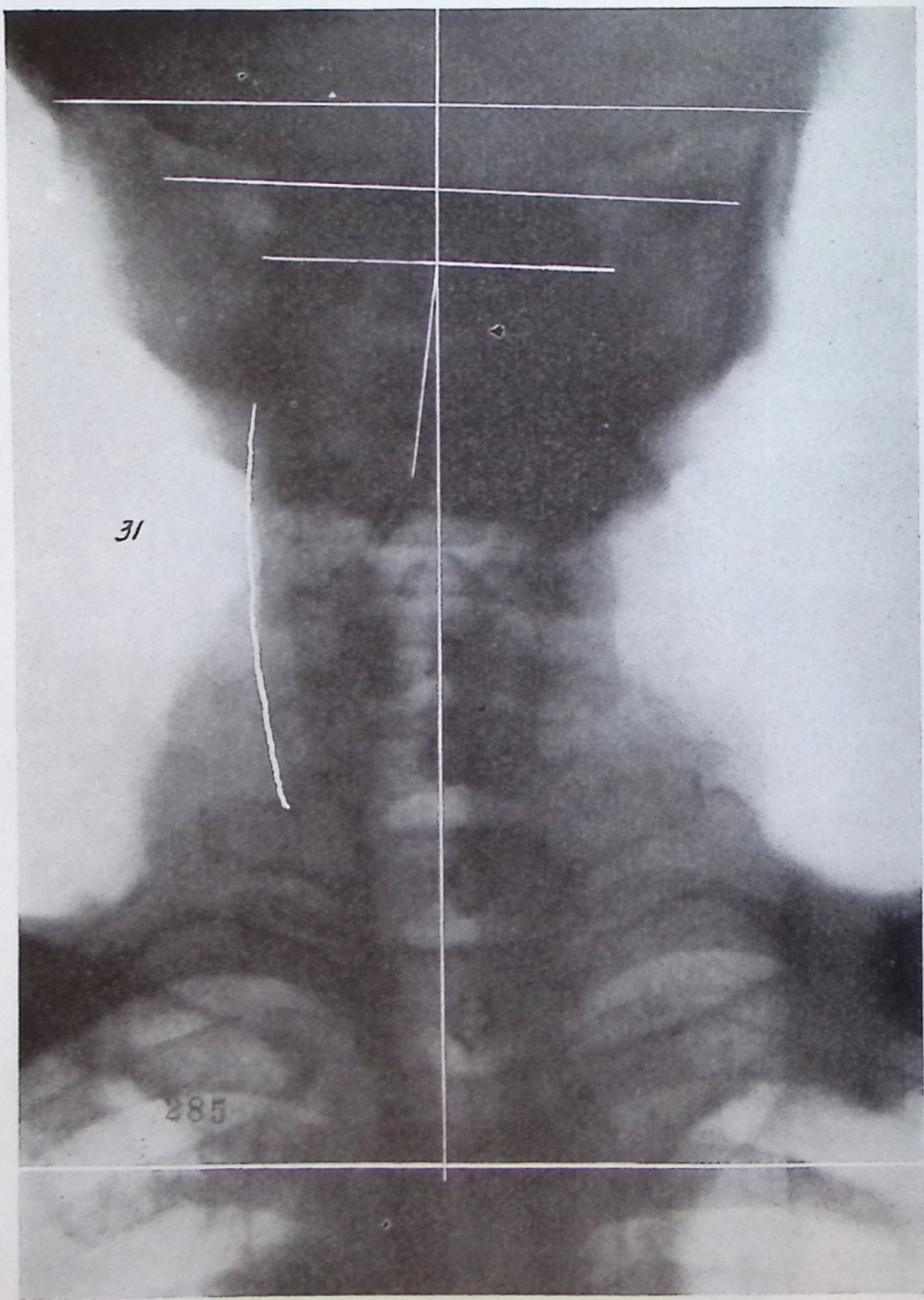


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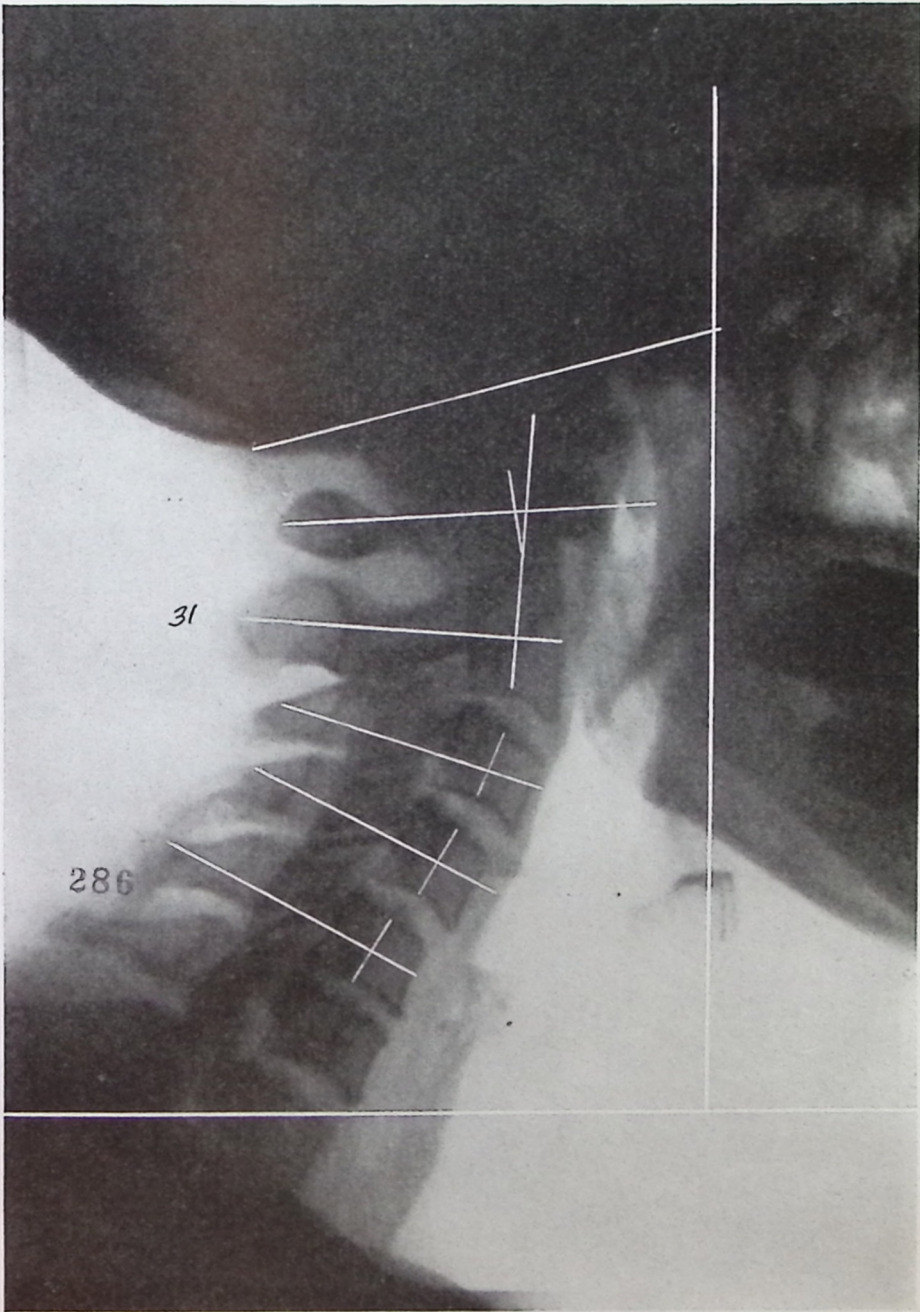


Illustration No. 286



Illustration No. 287

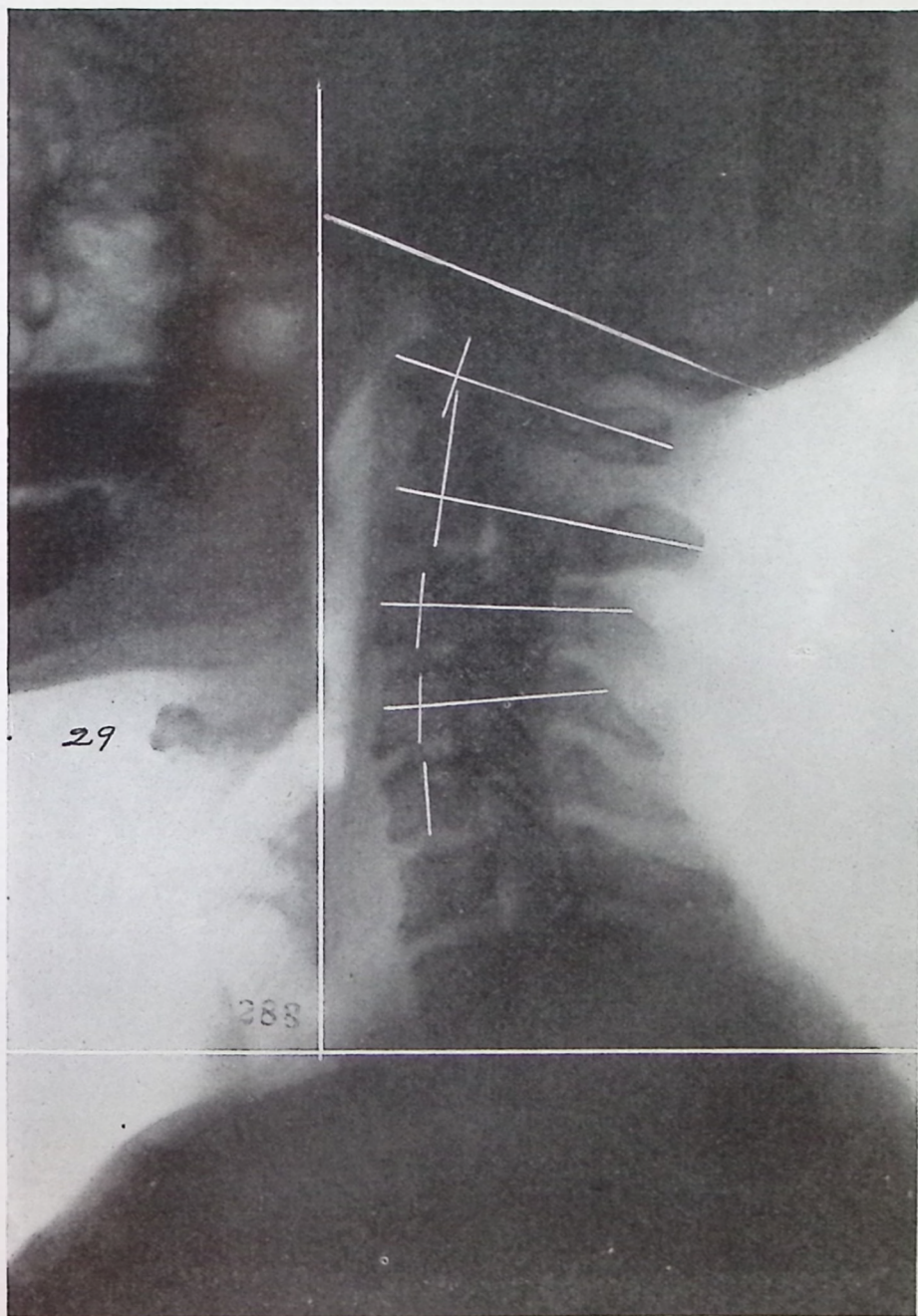


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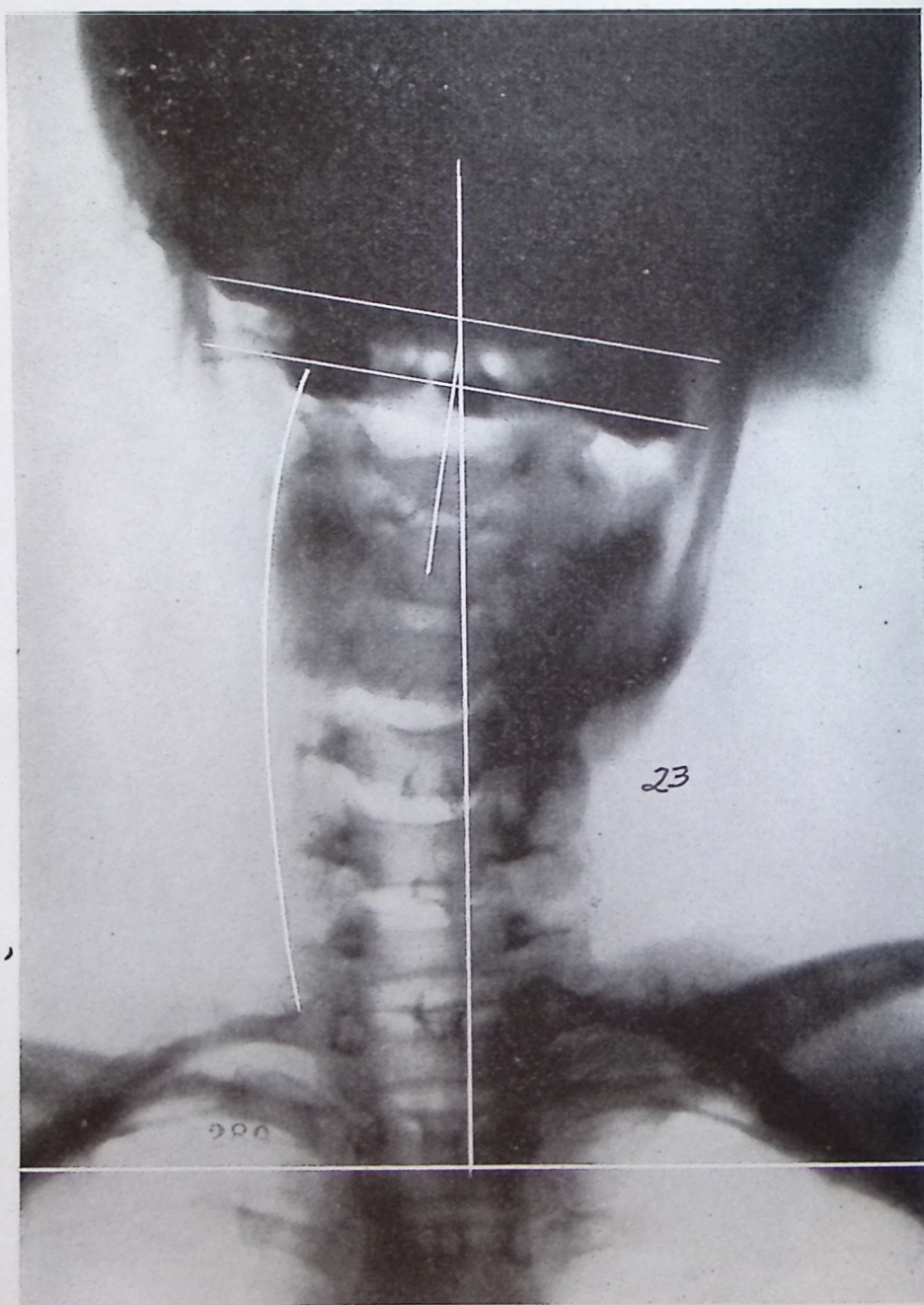


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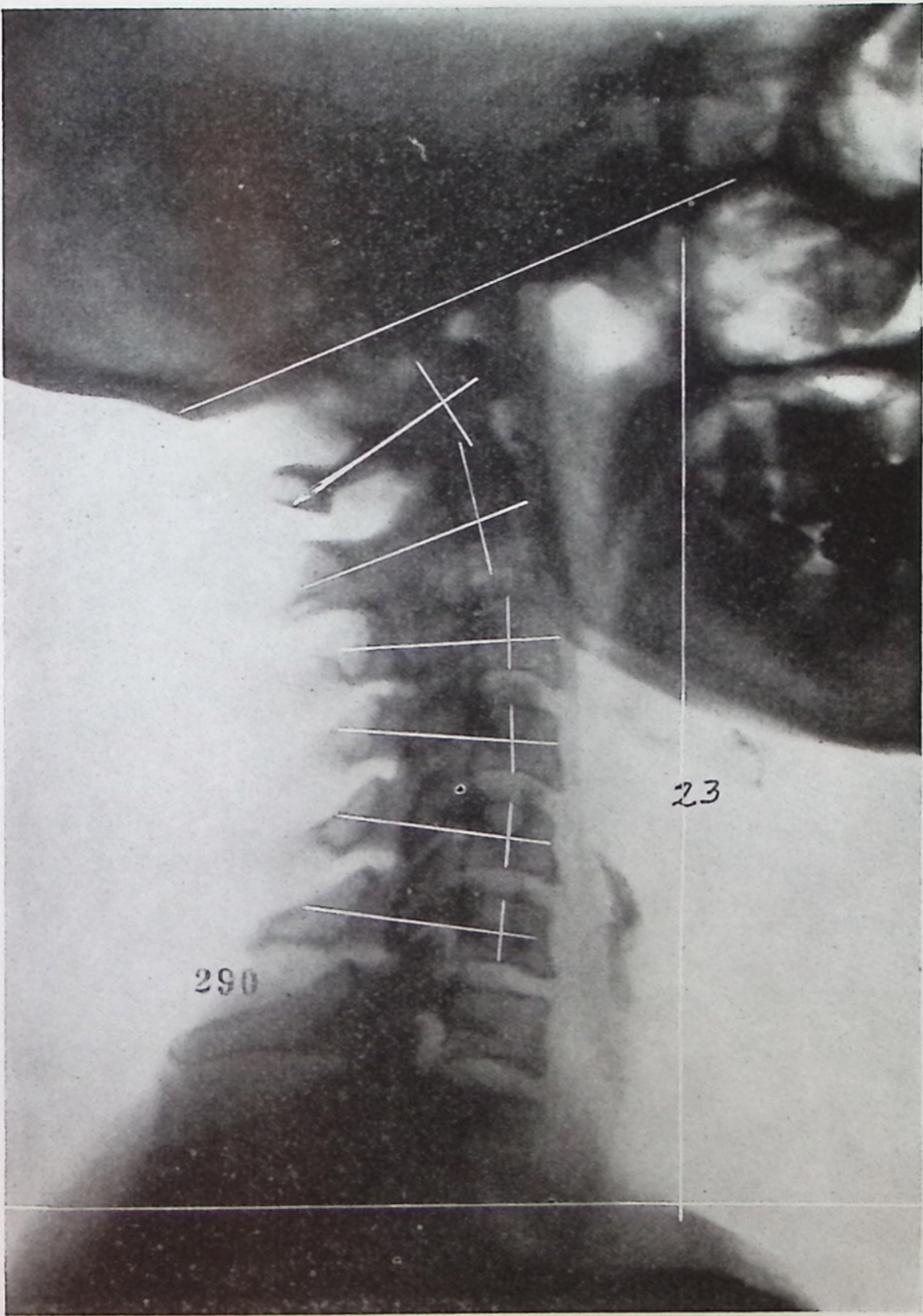


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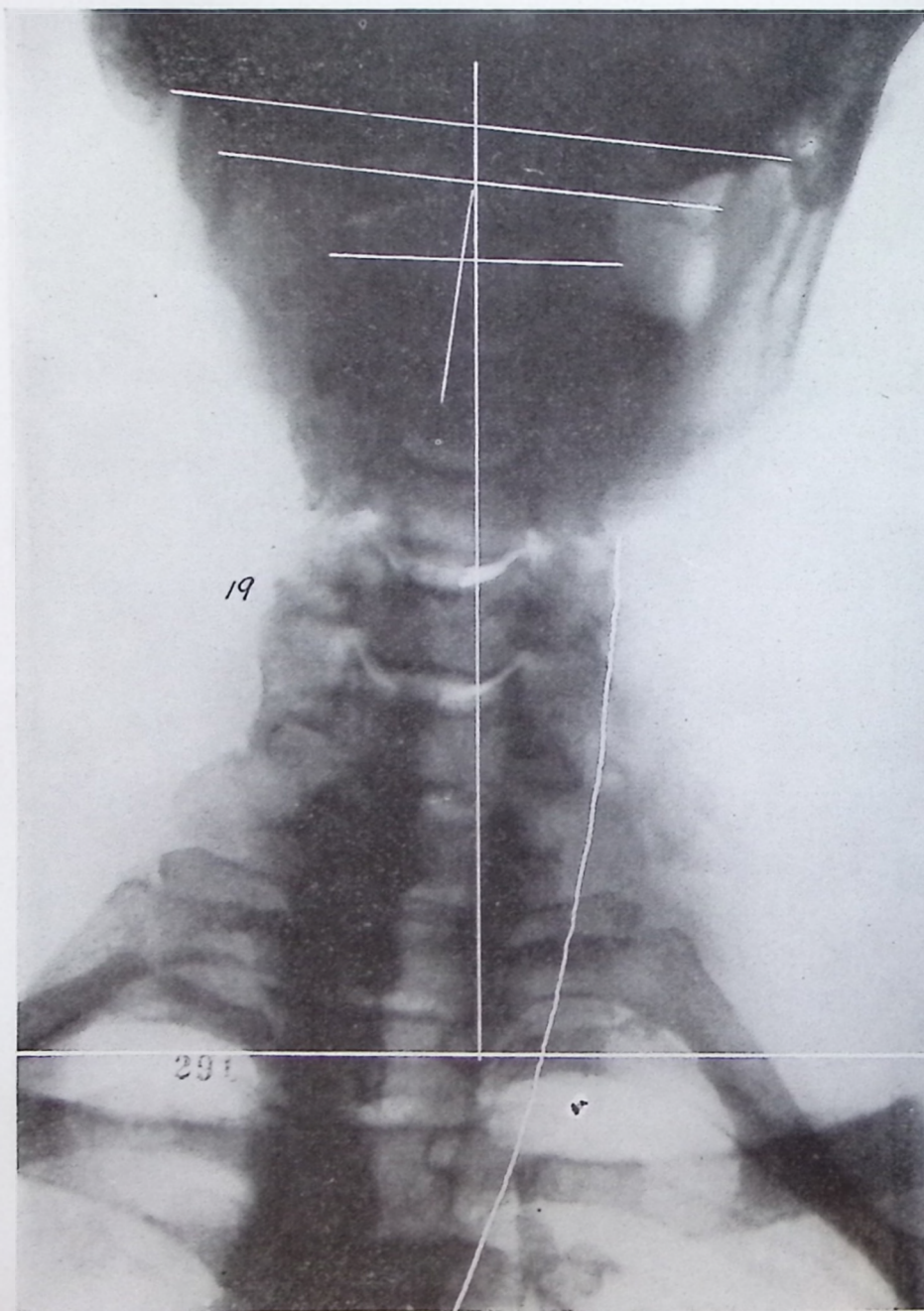


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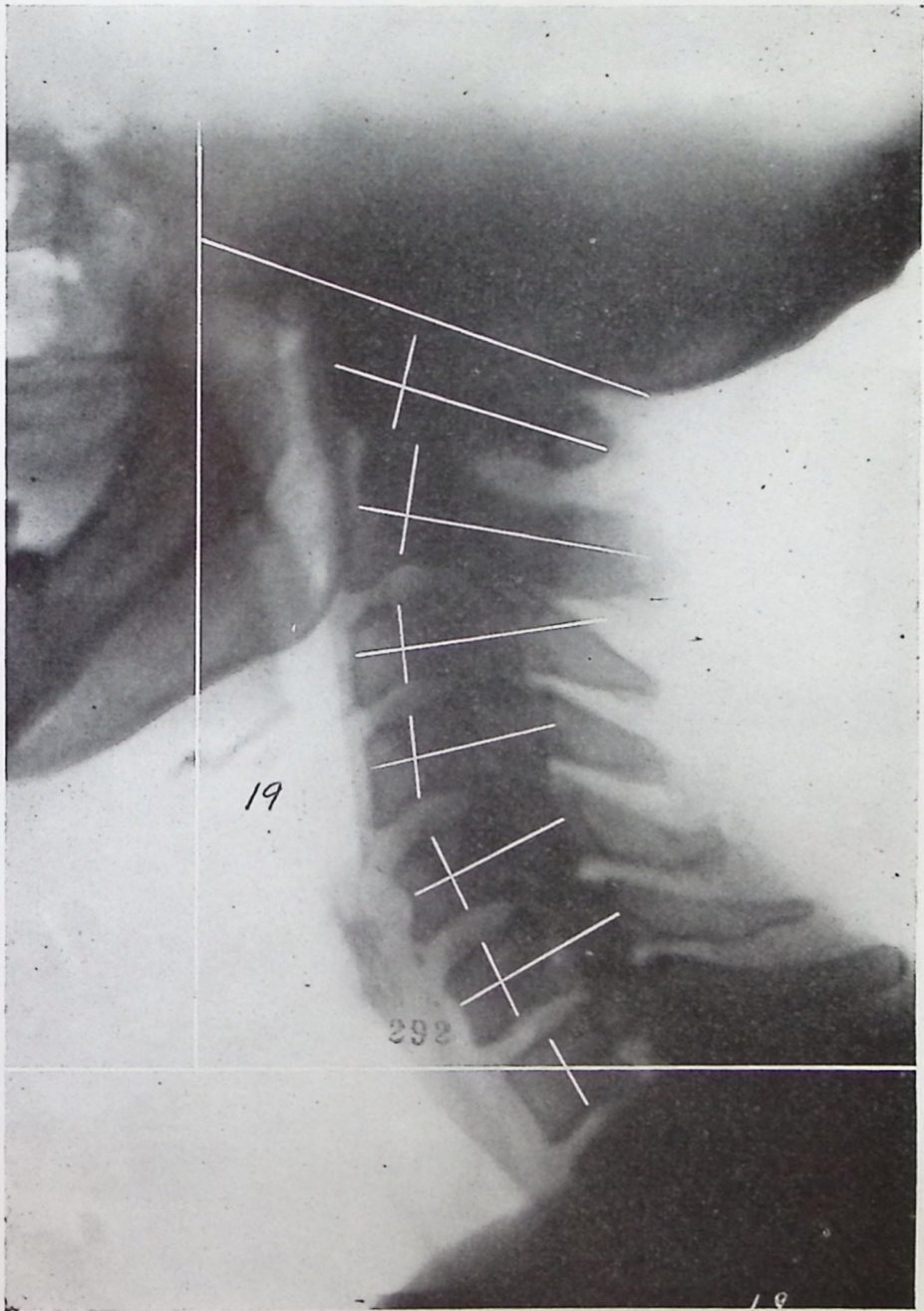


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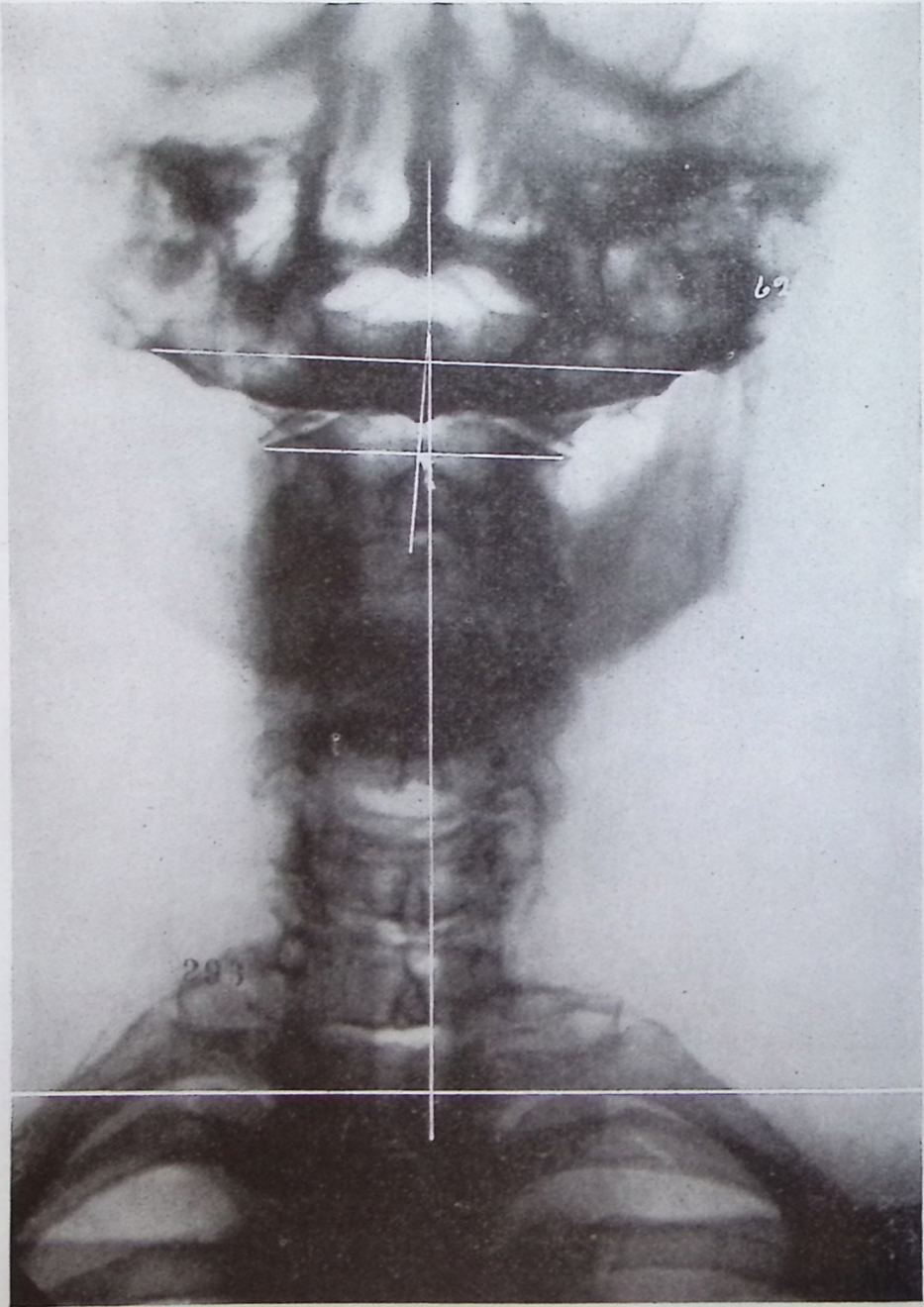


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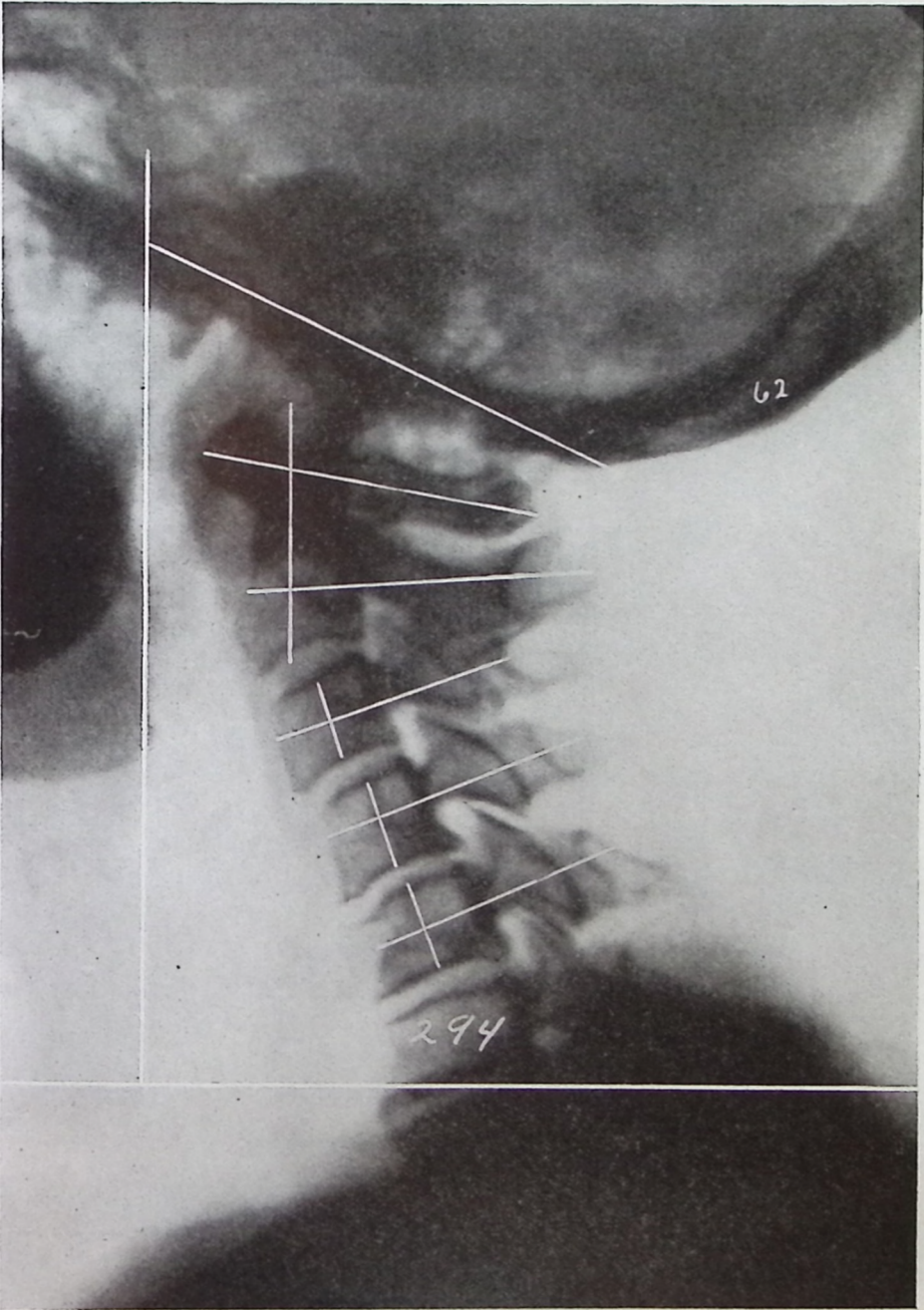


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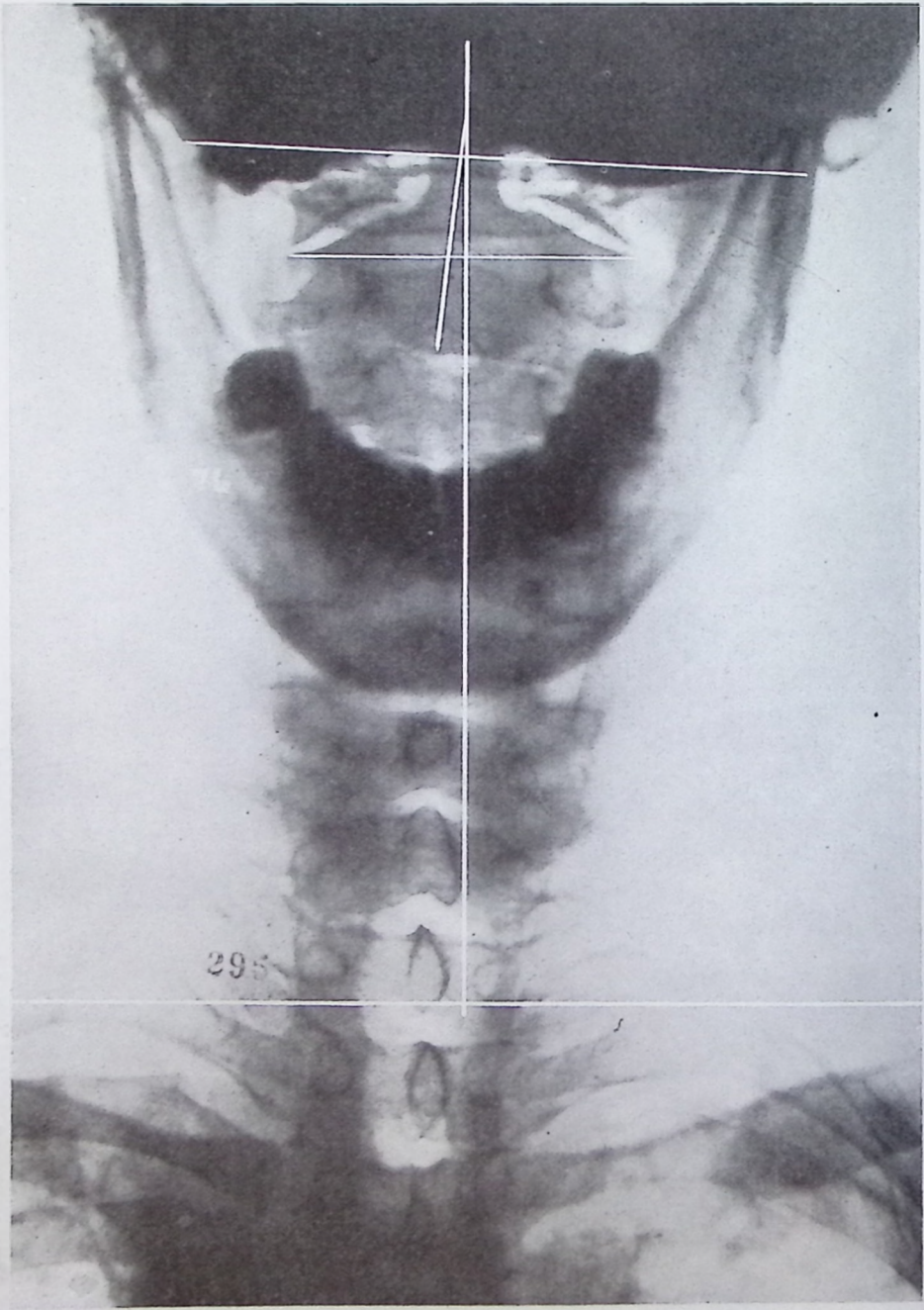


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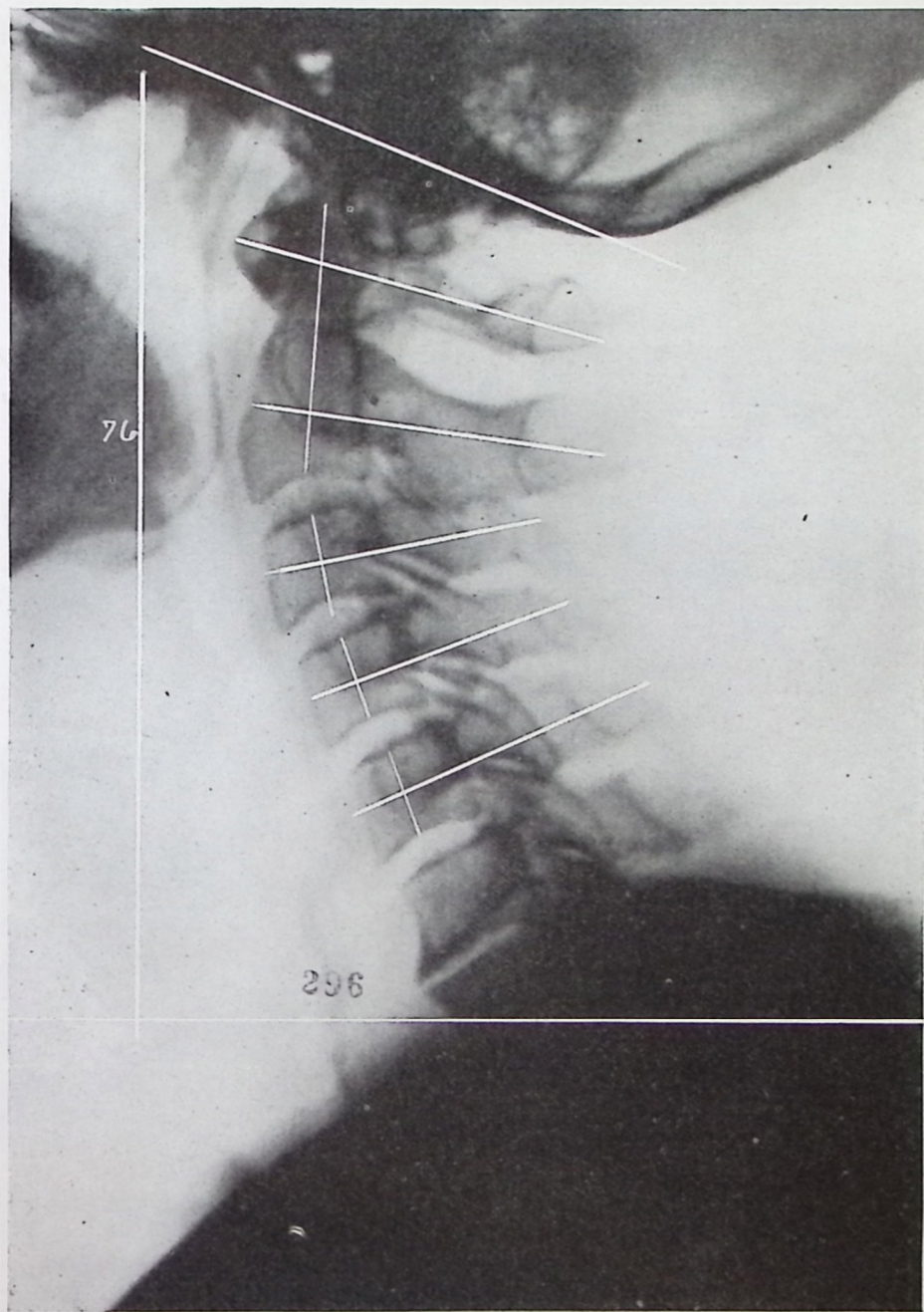


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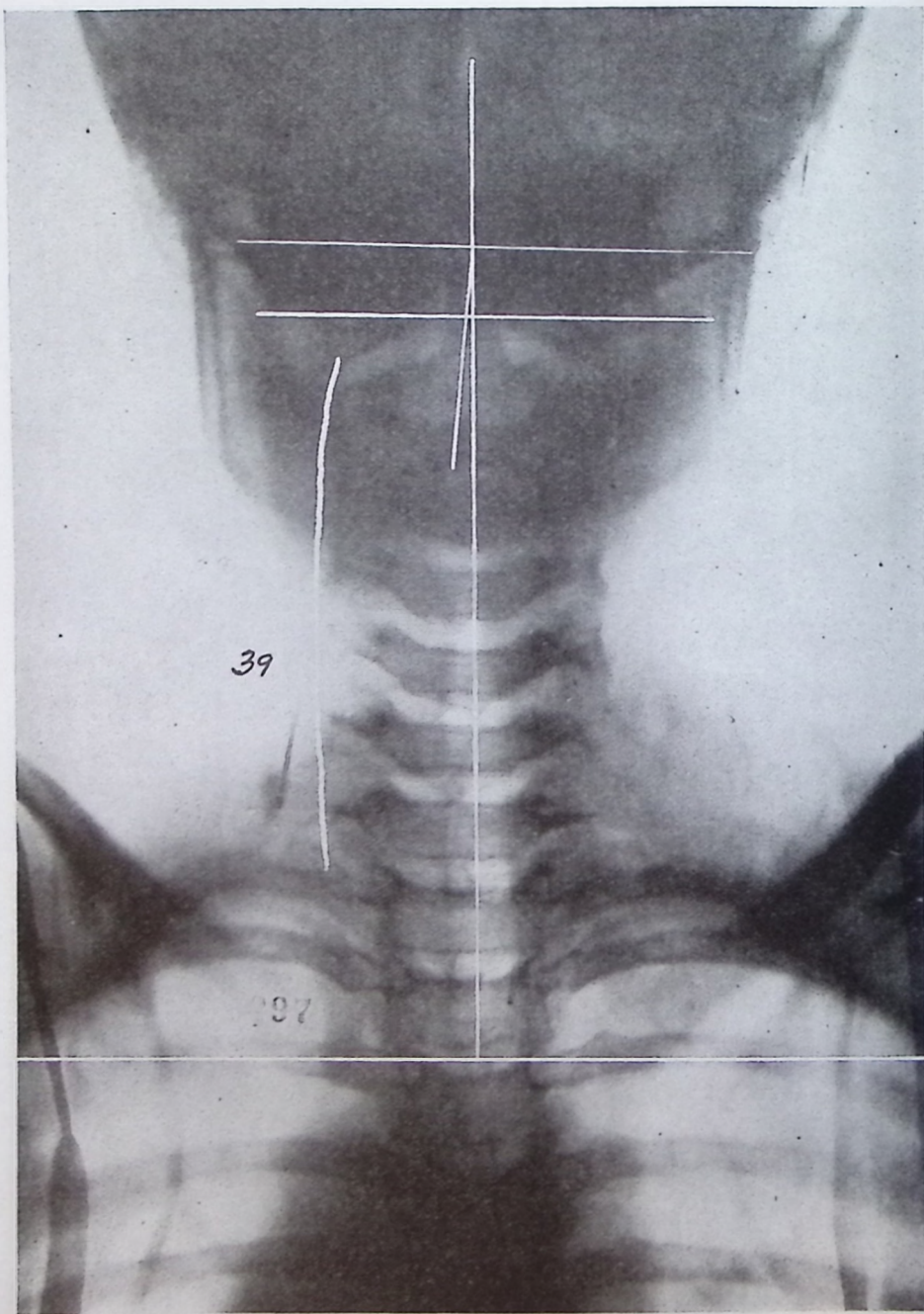


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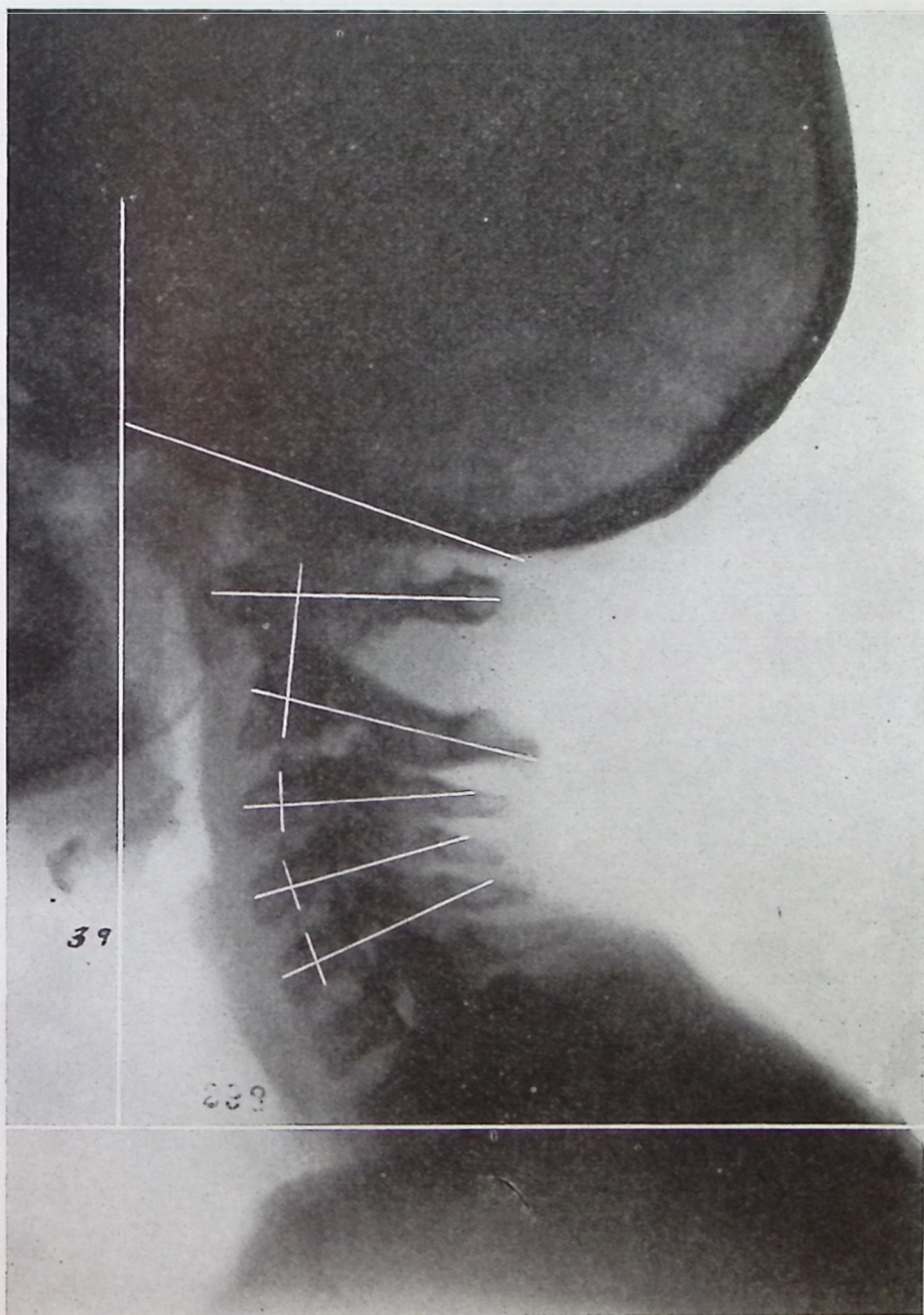


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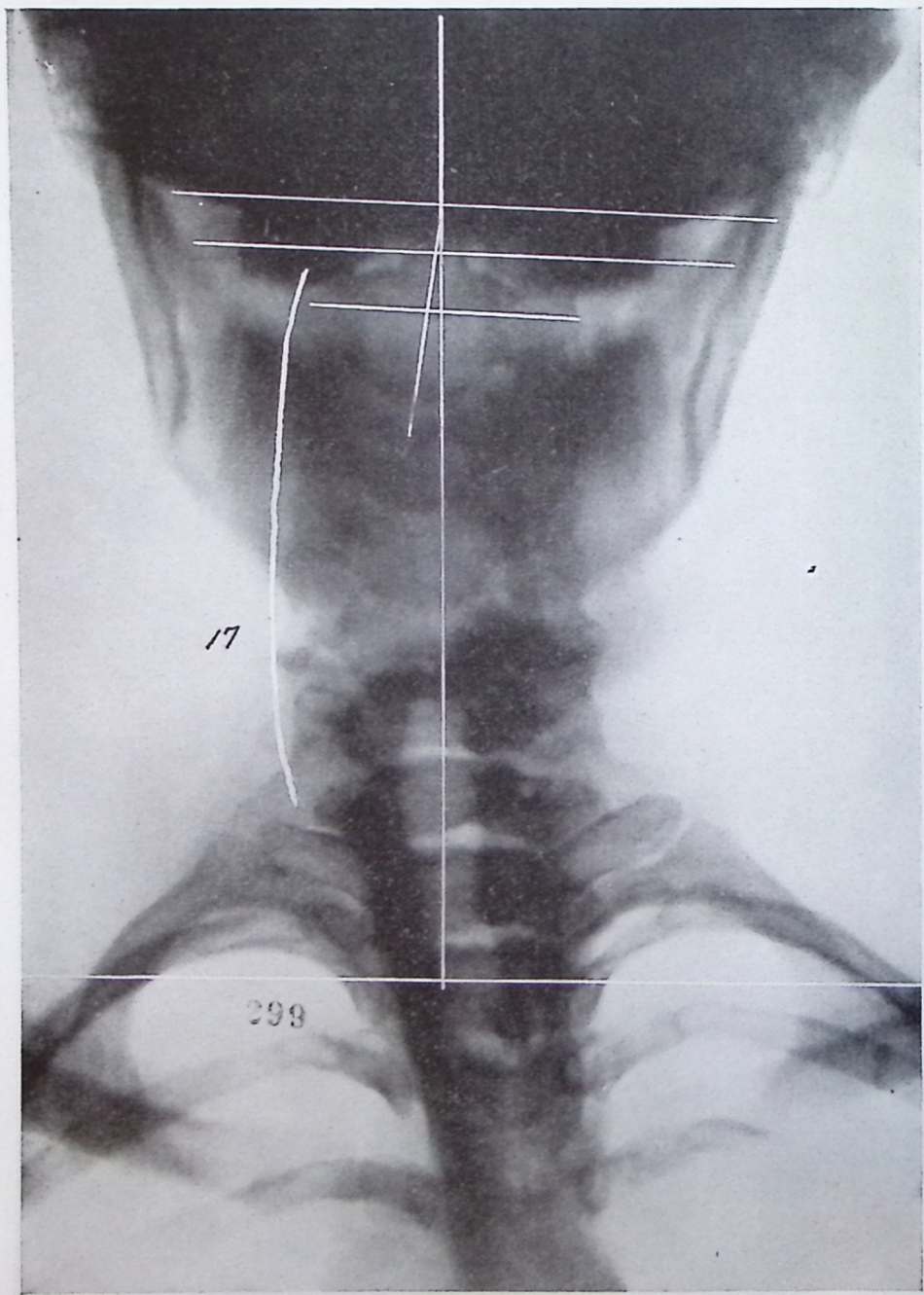


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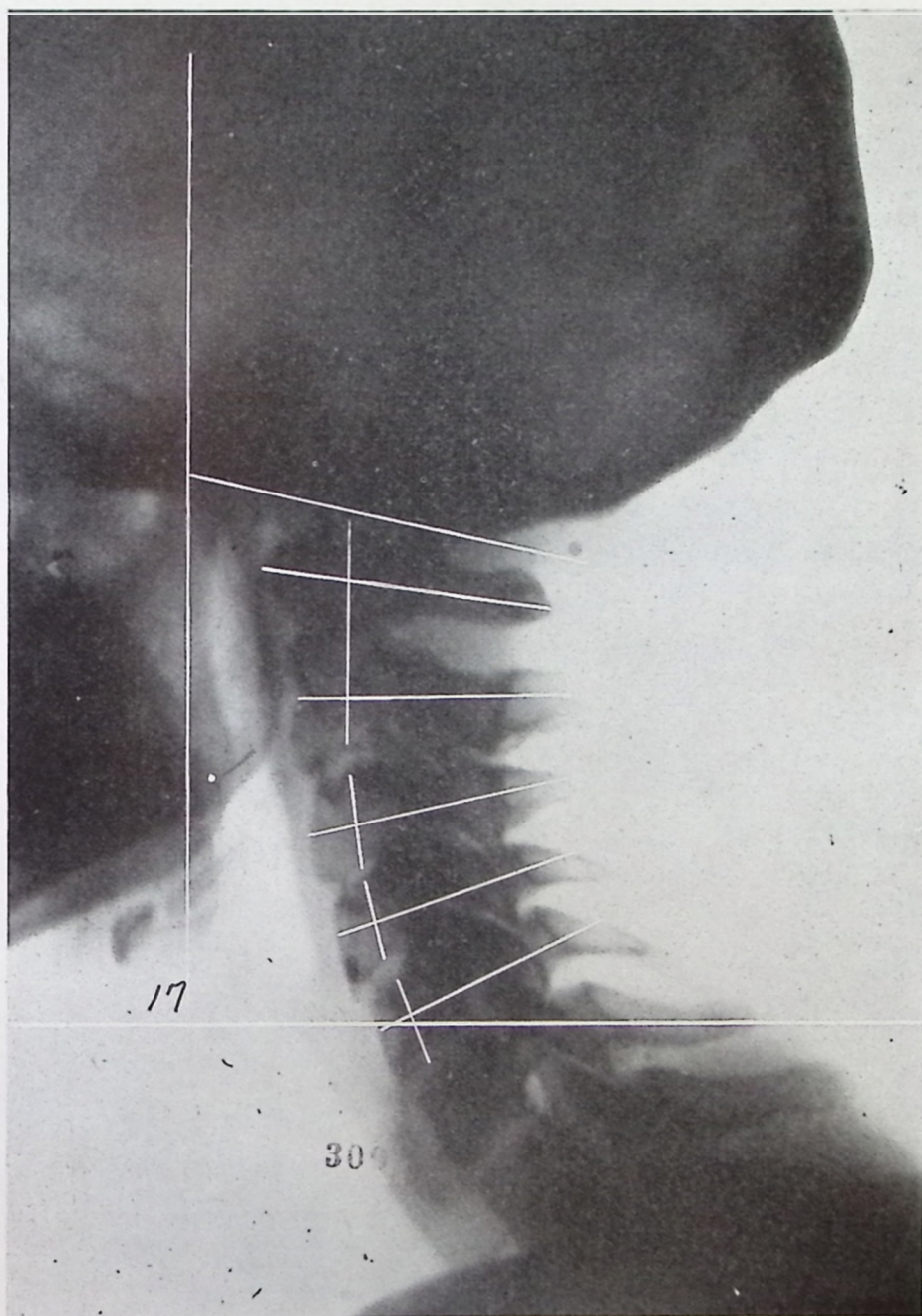


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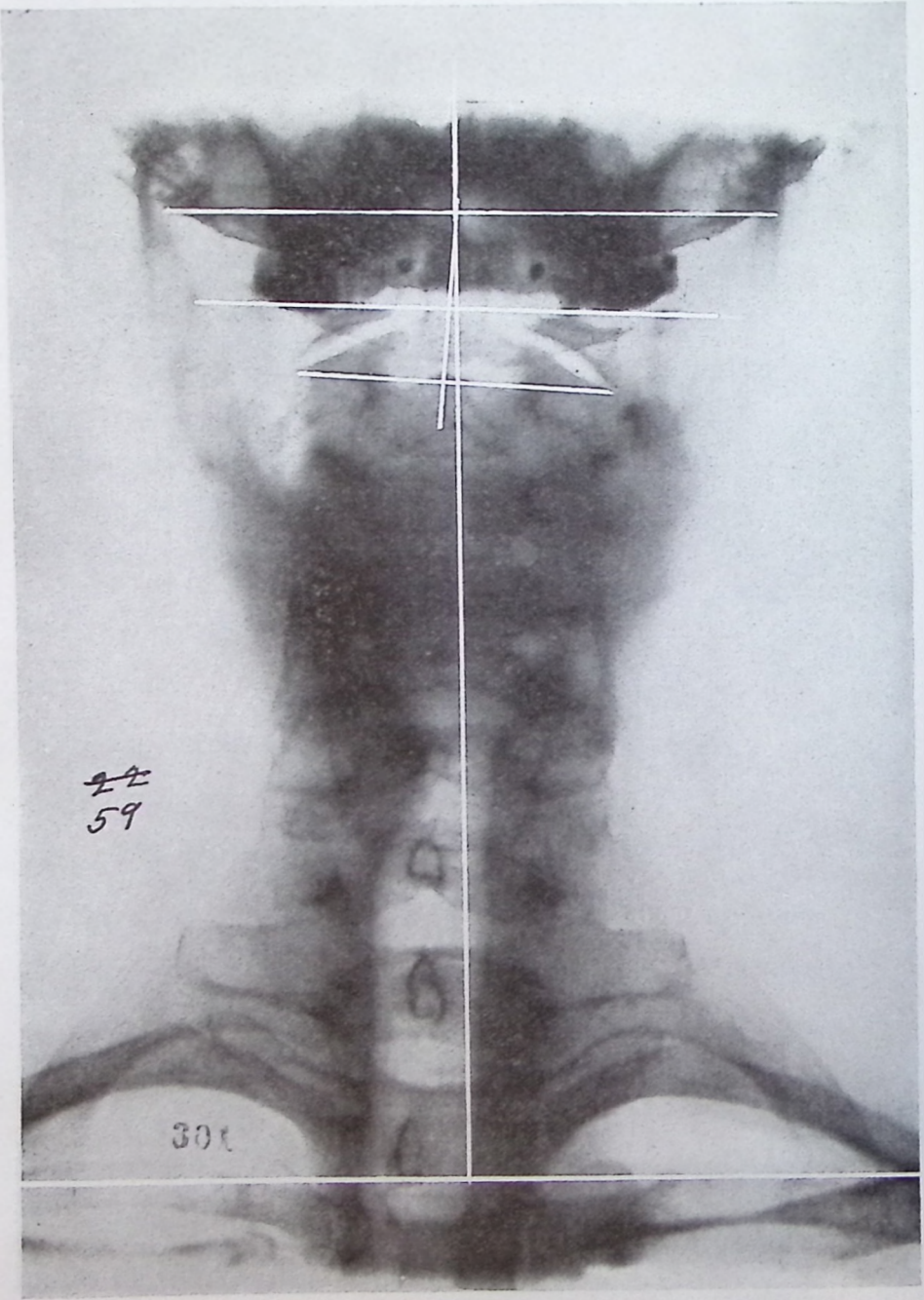


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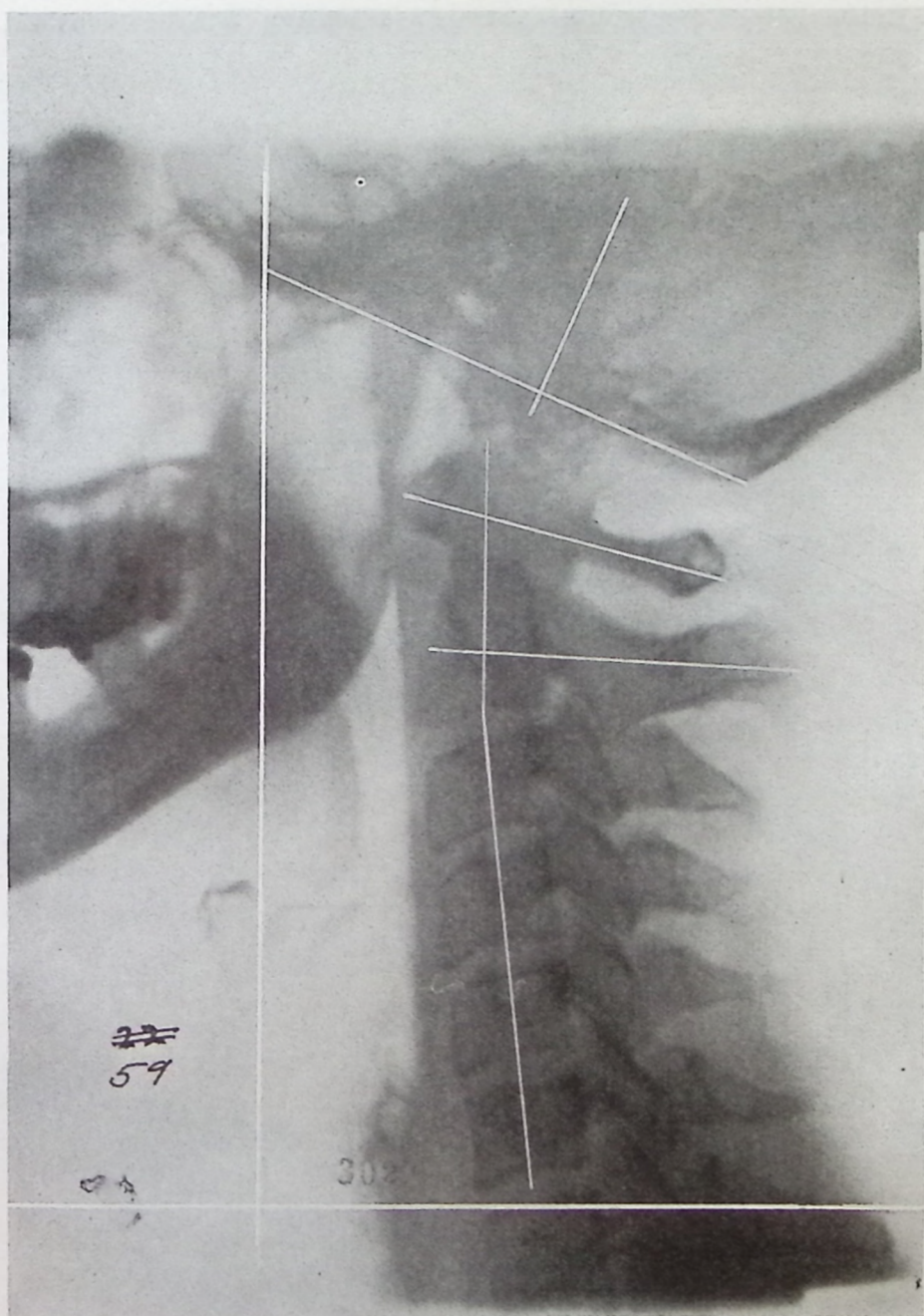


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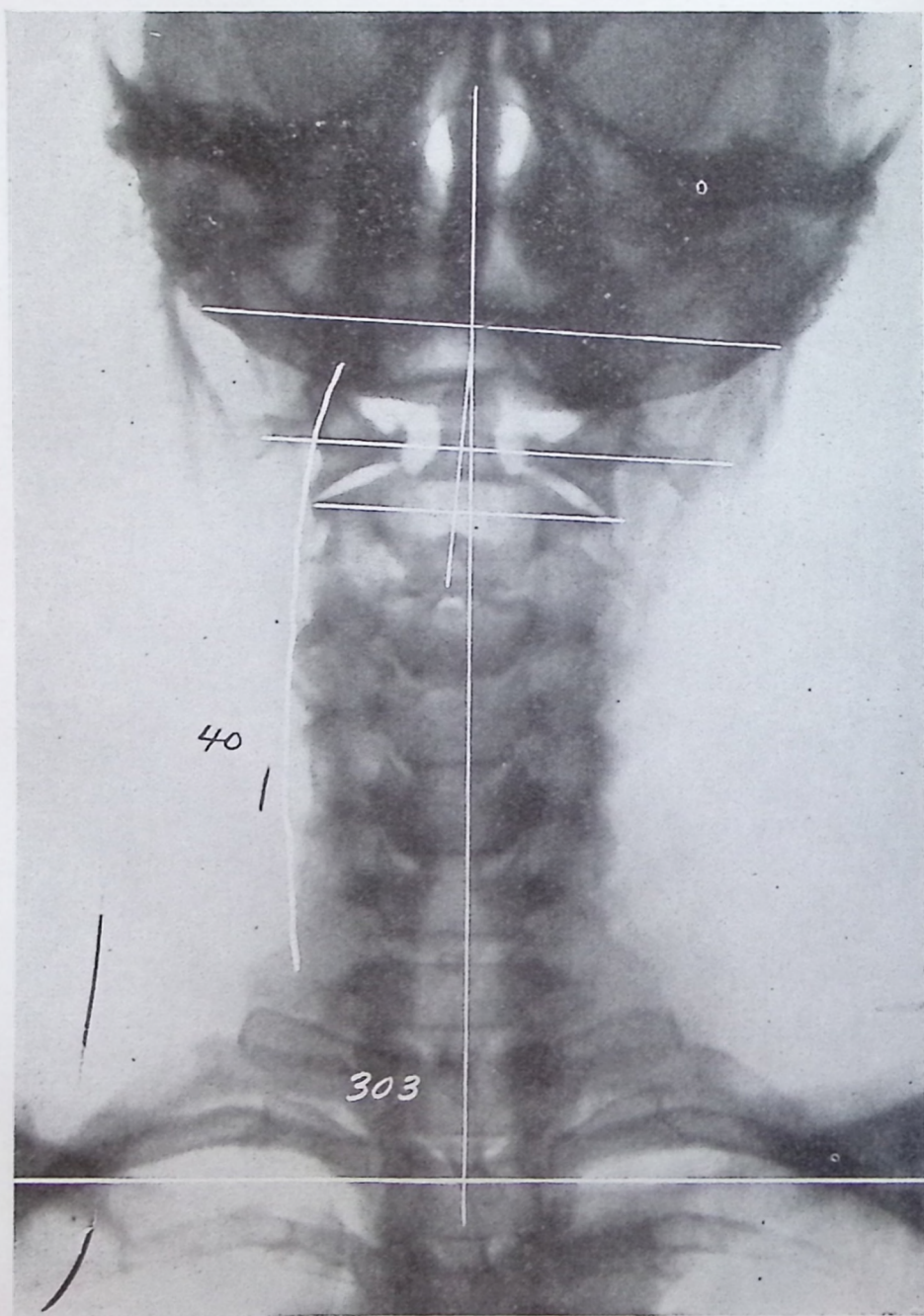


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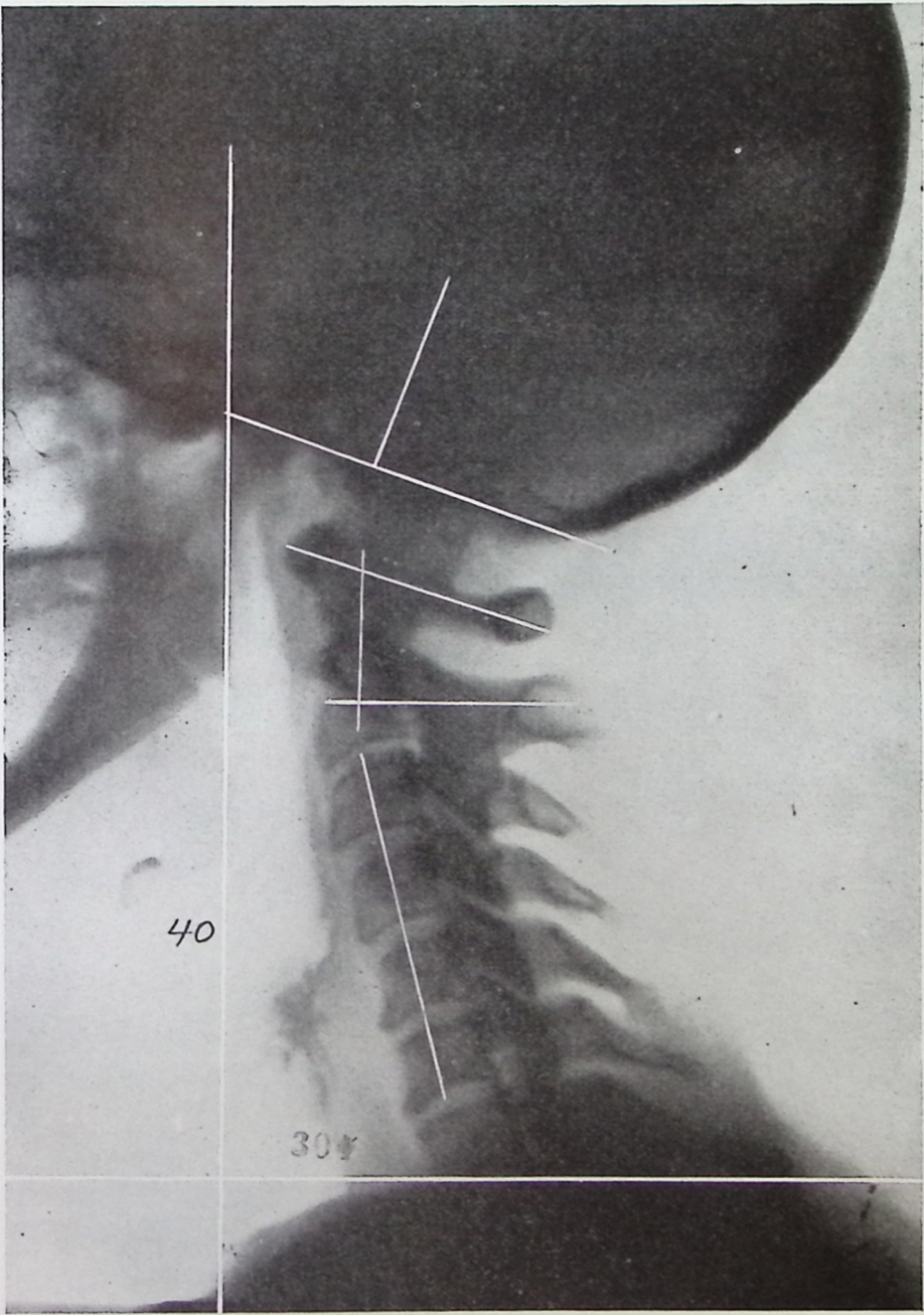


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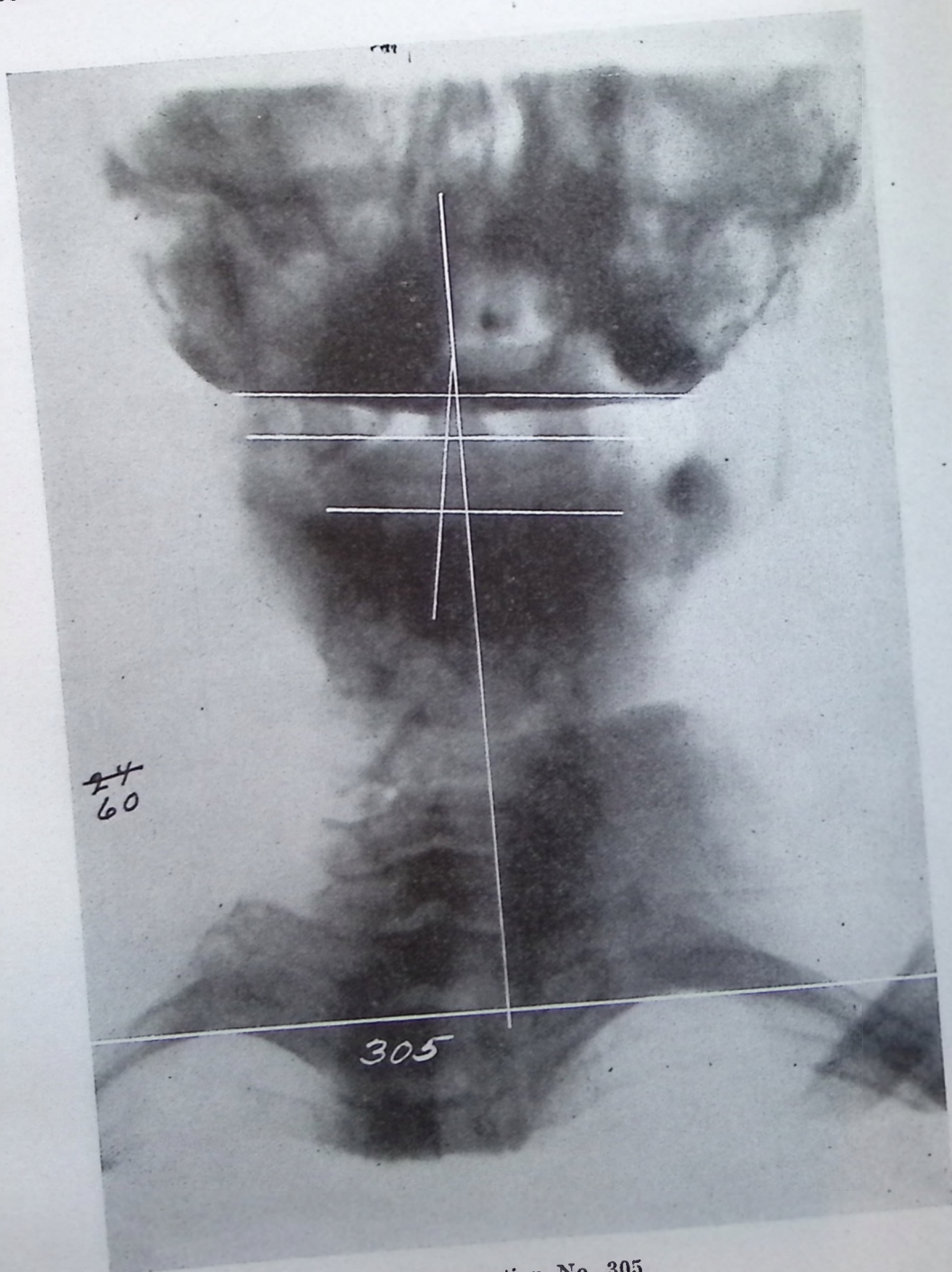


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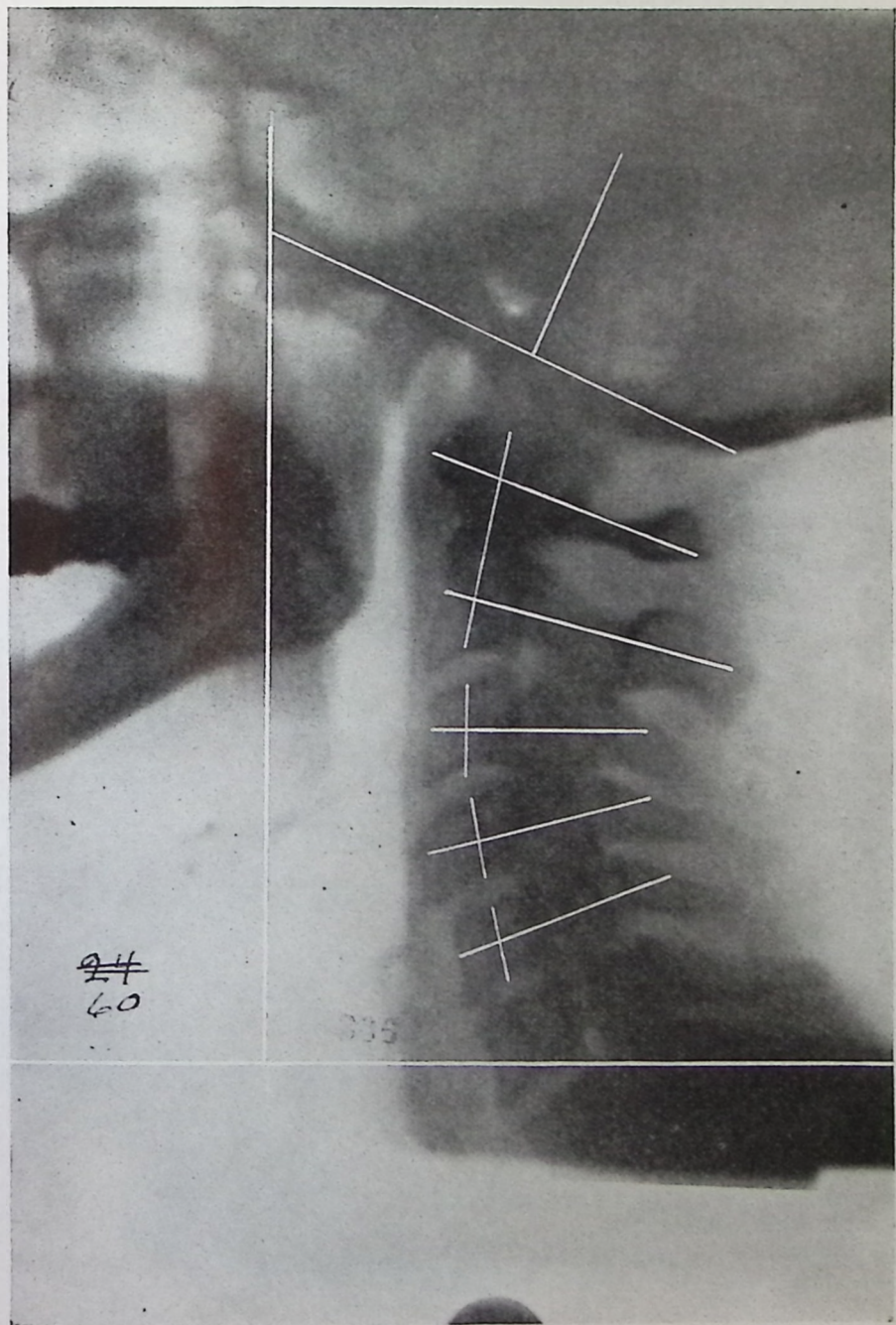


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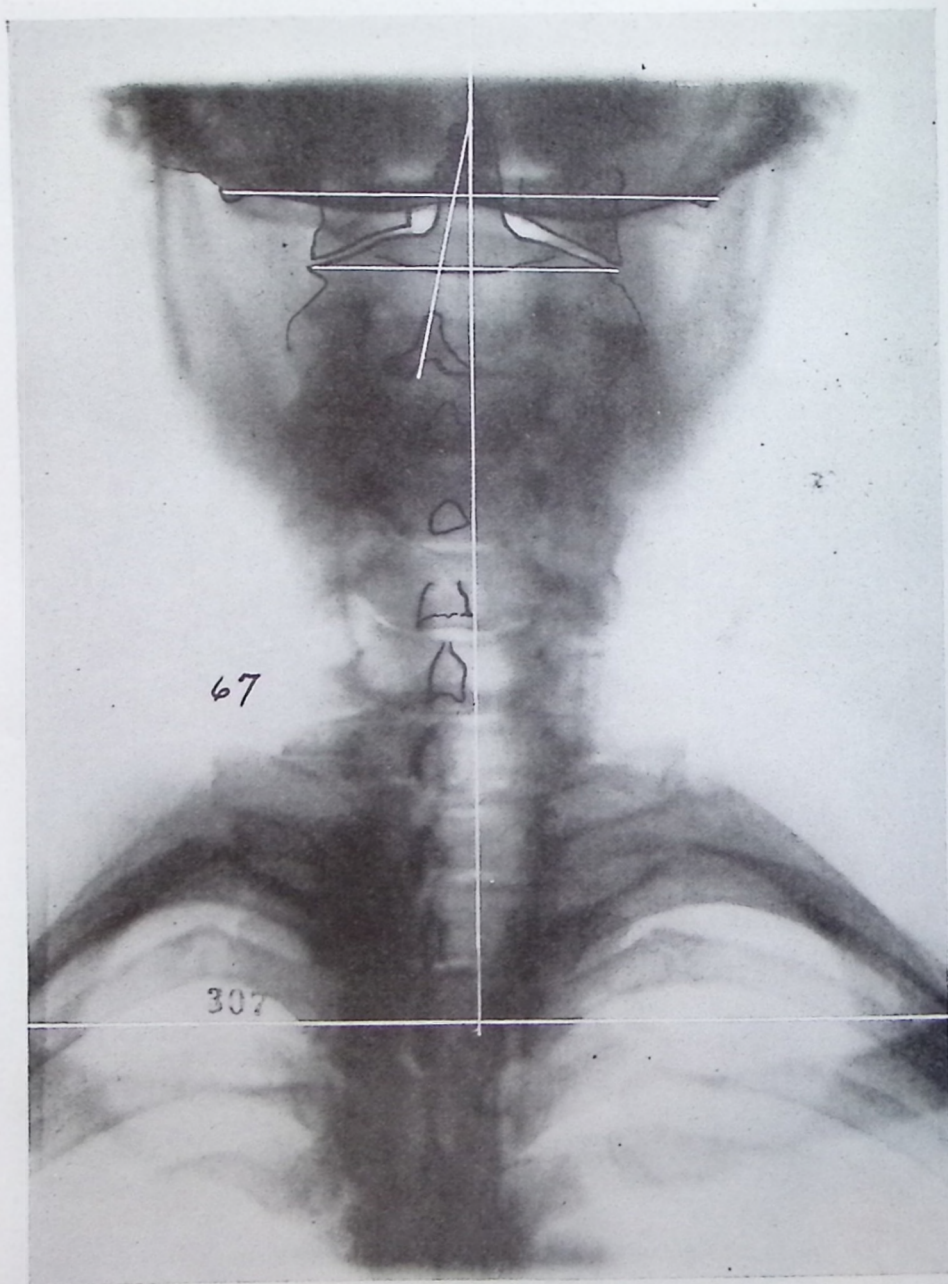


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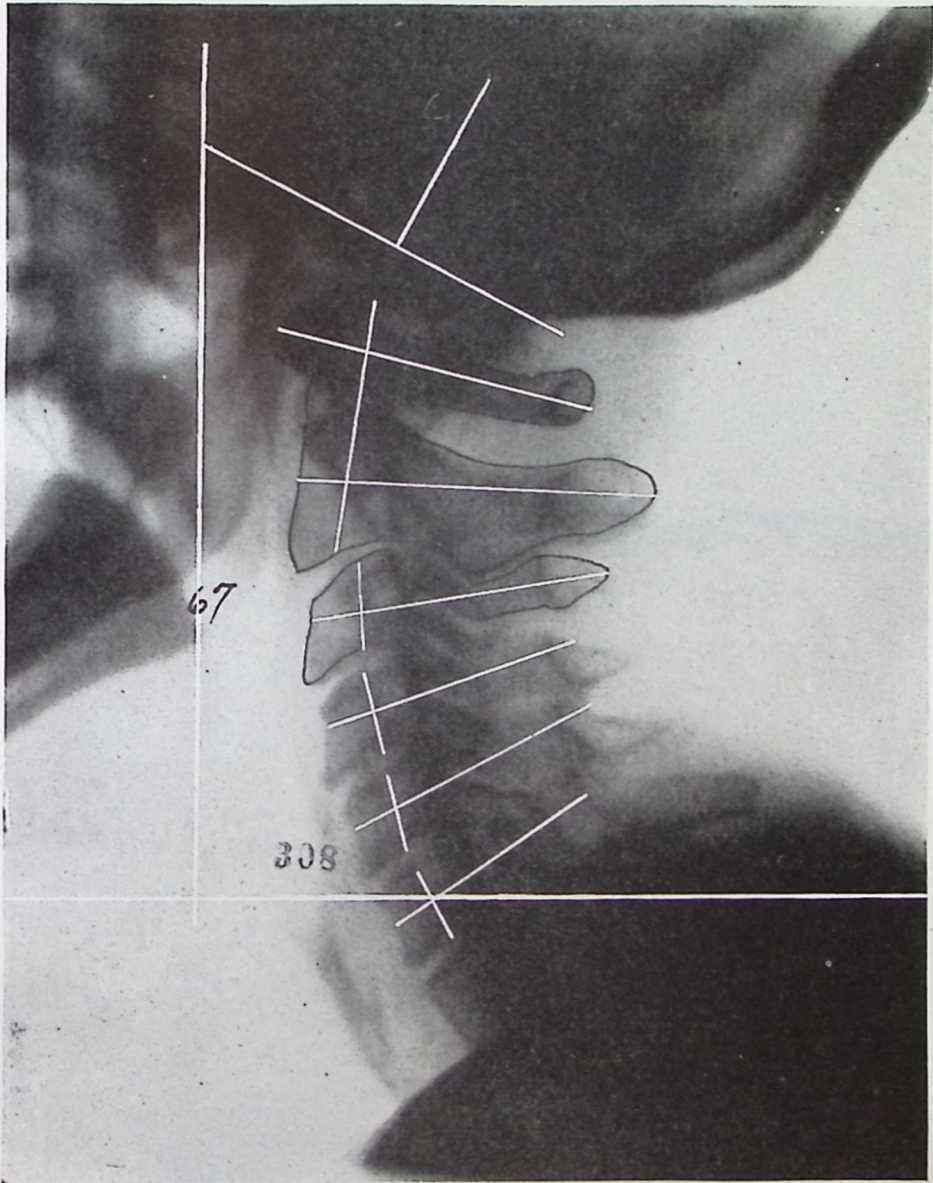


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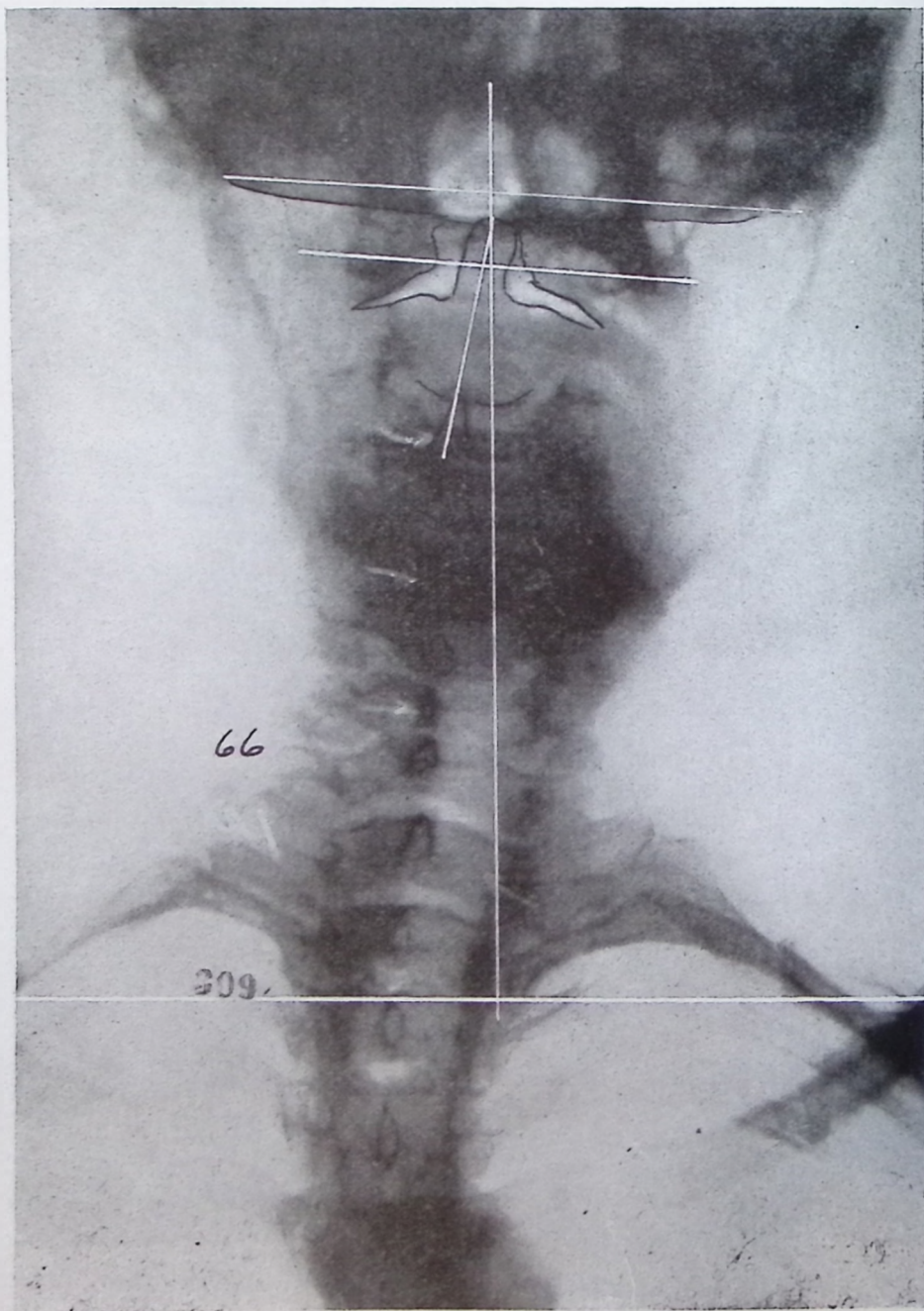


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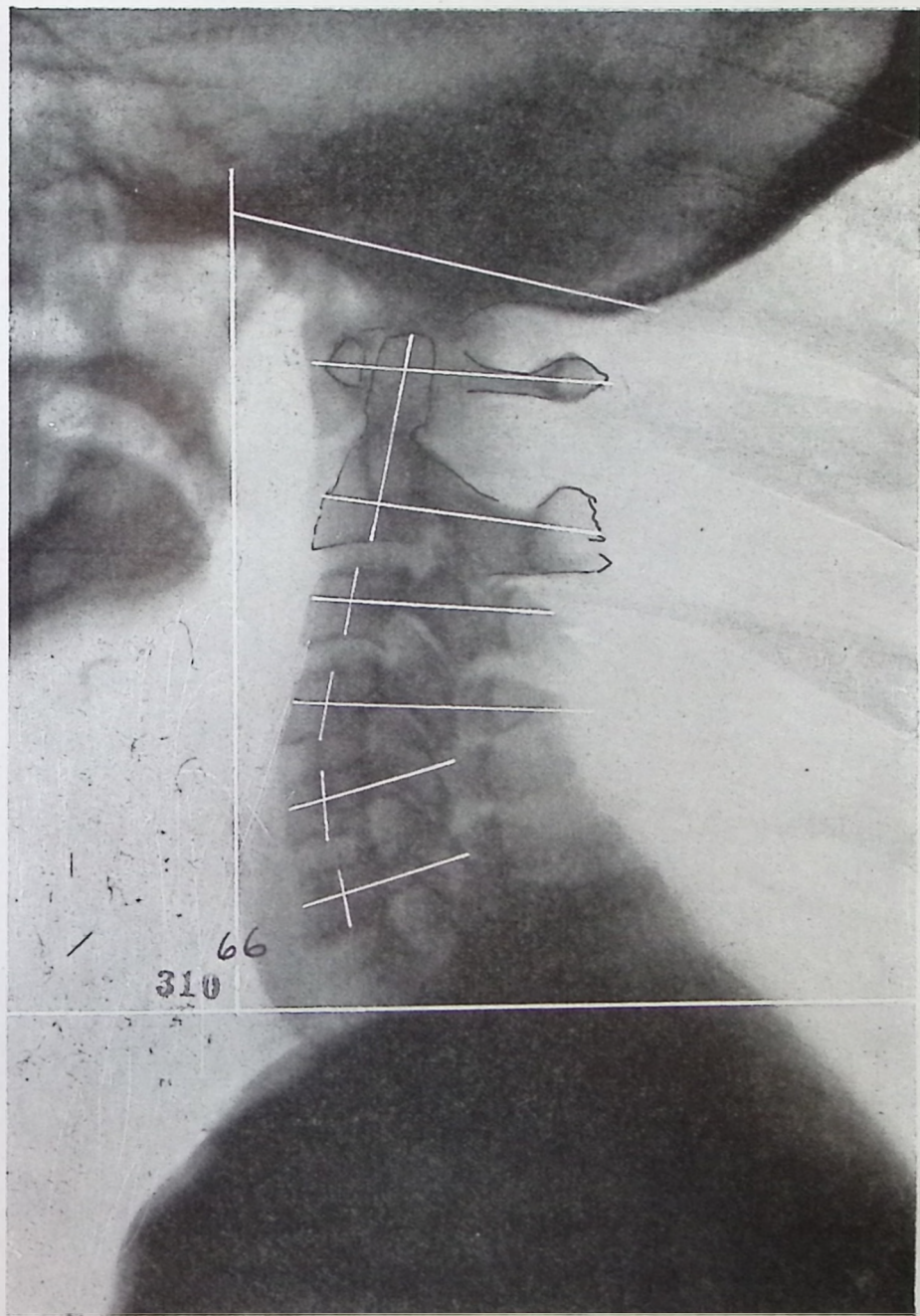


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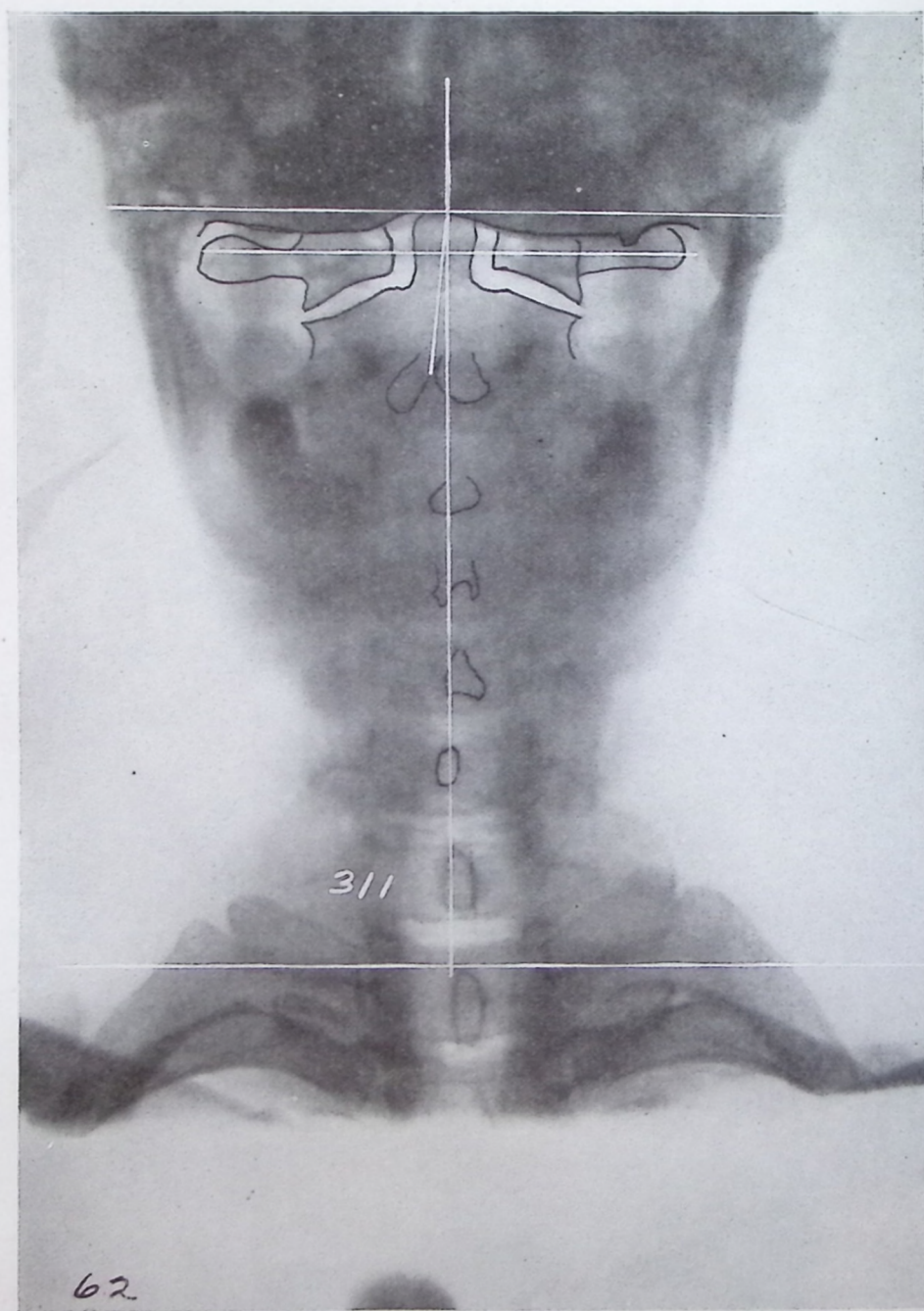


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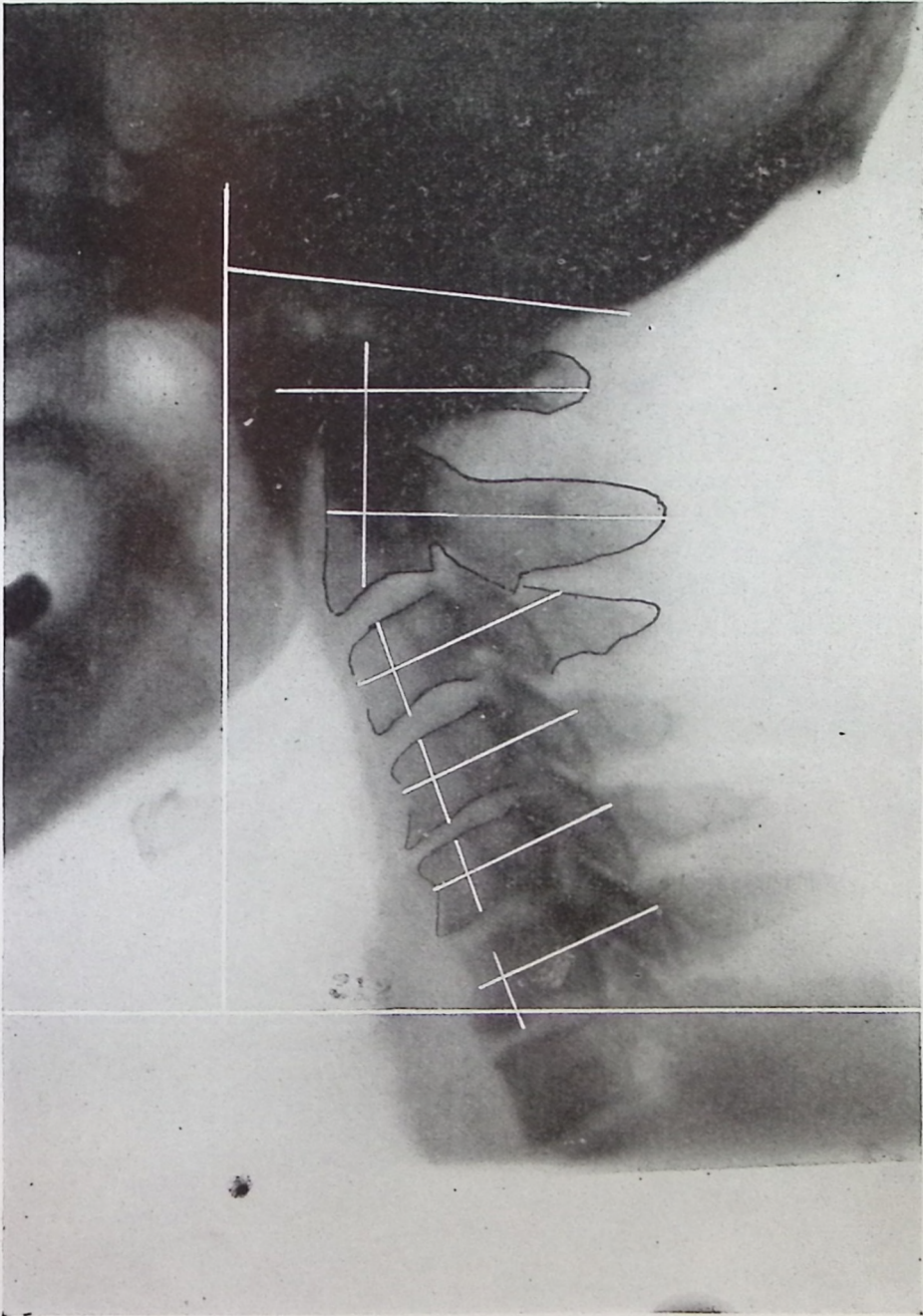


Illustration No. 312



Illustration No. 313

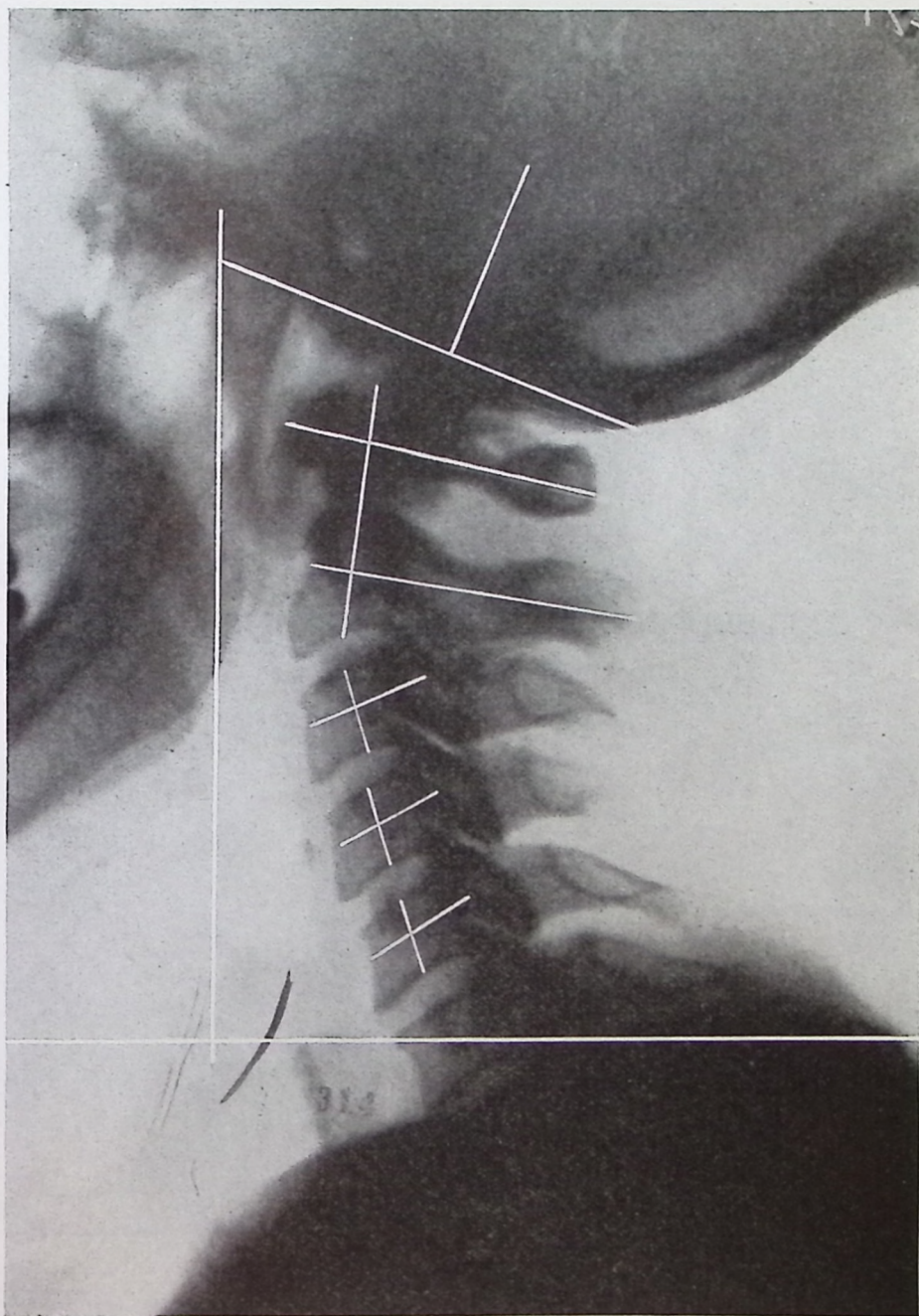


Illustration No. 314

CHAPTER XXXI.

AXIS PRI TRUE SUBLUXATION PLANE LINES.

Illustrations No. 315 to 340

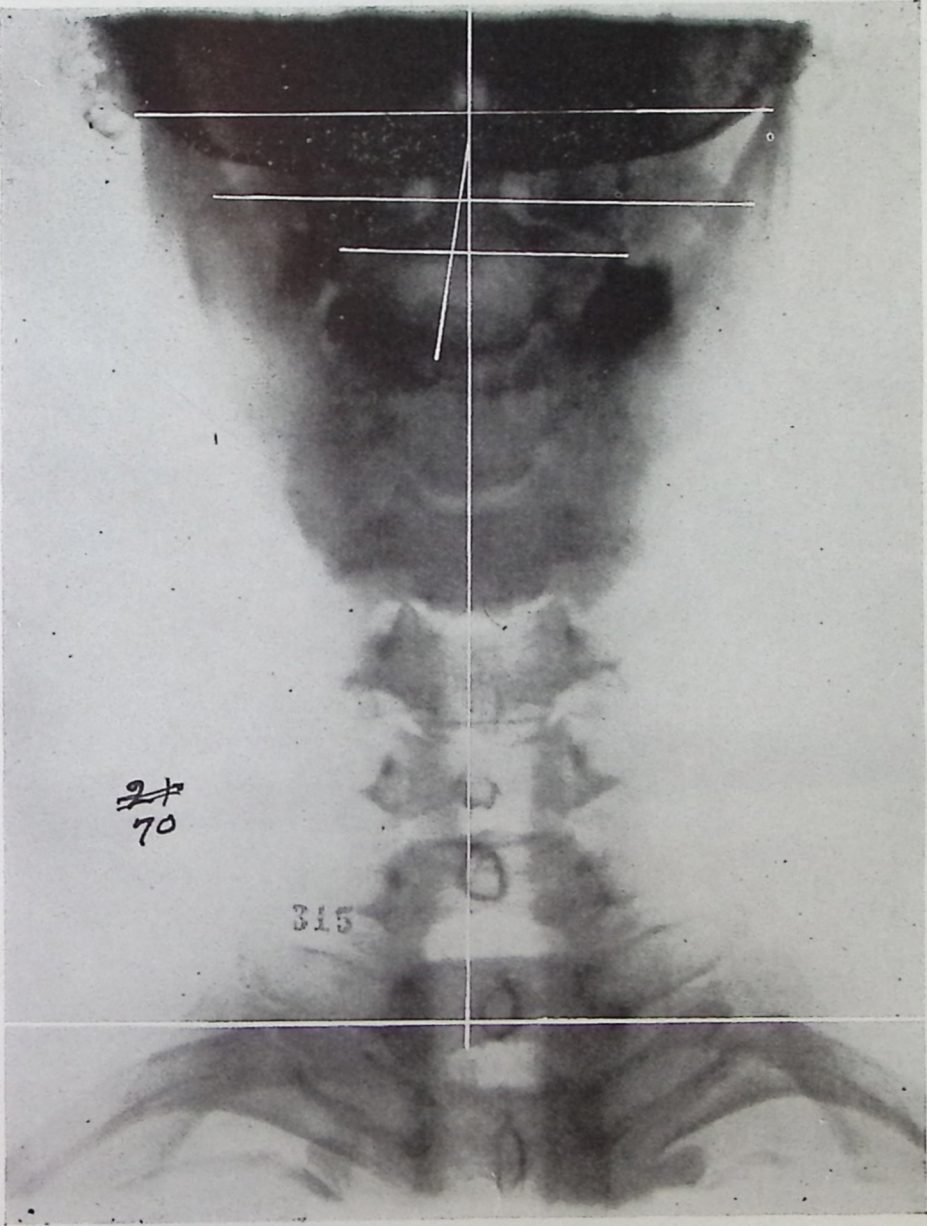


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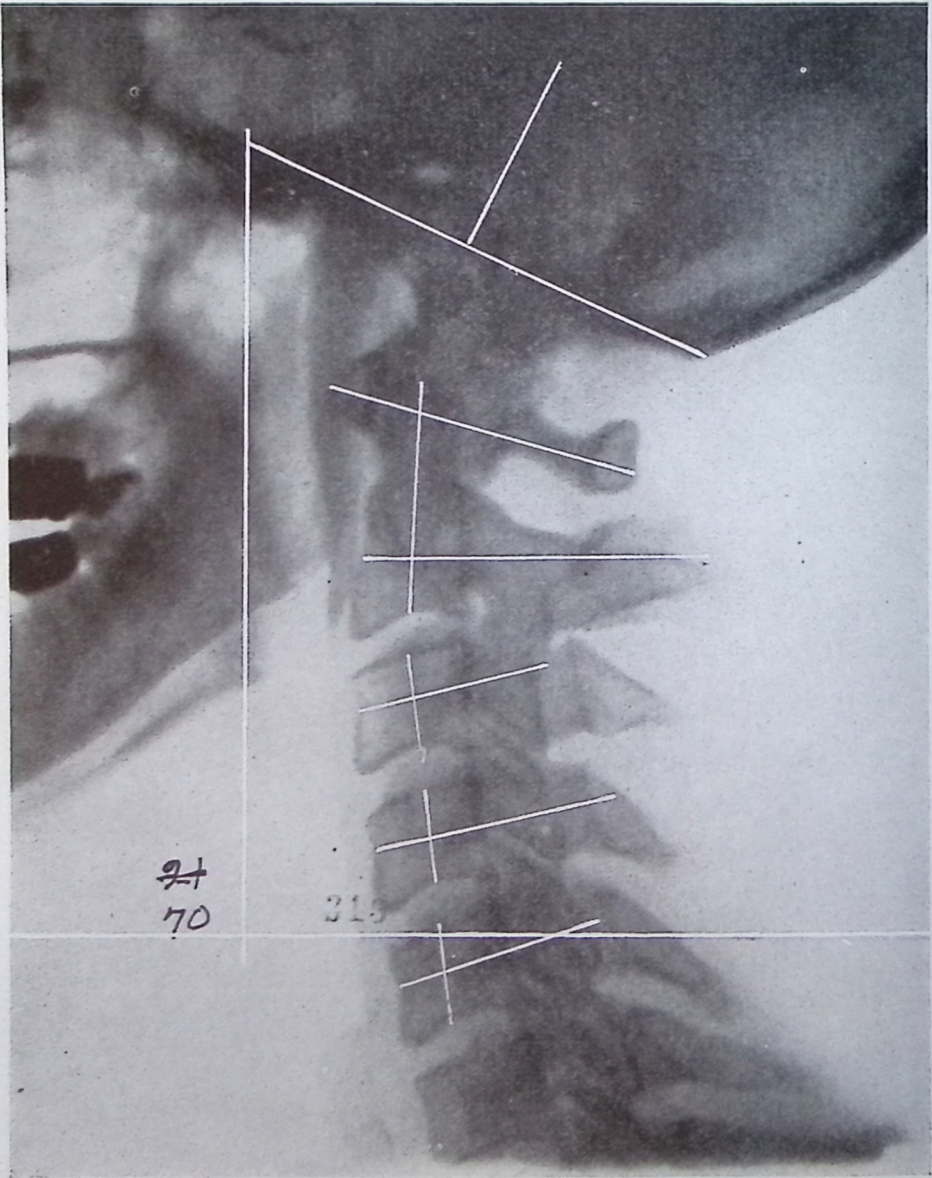


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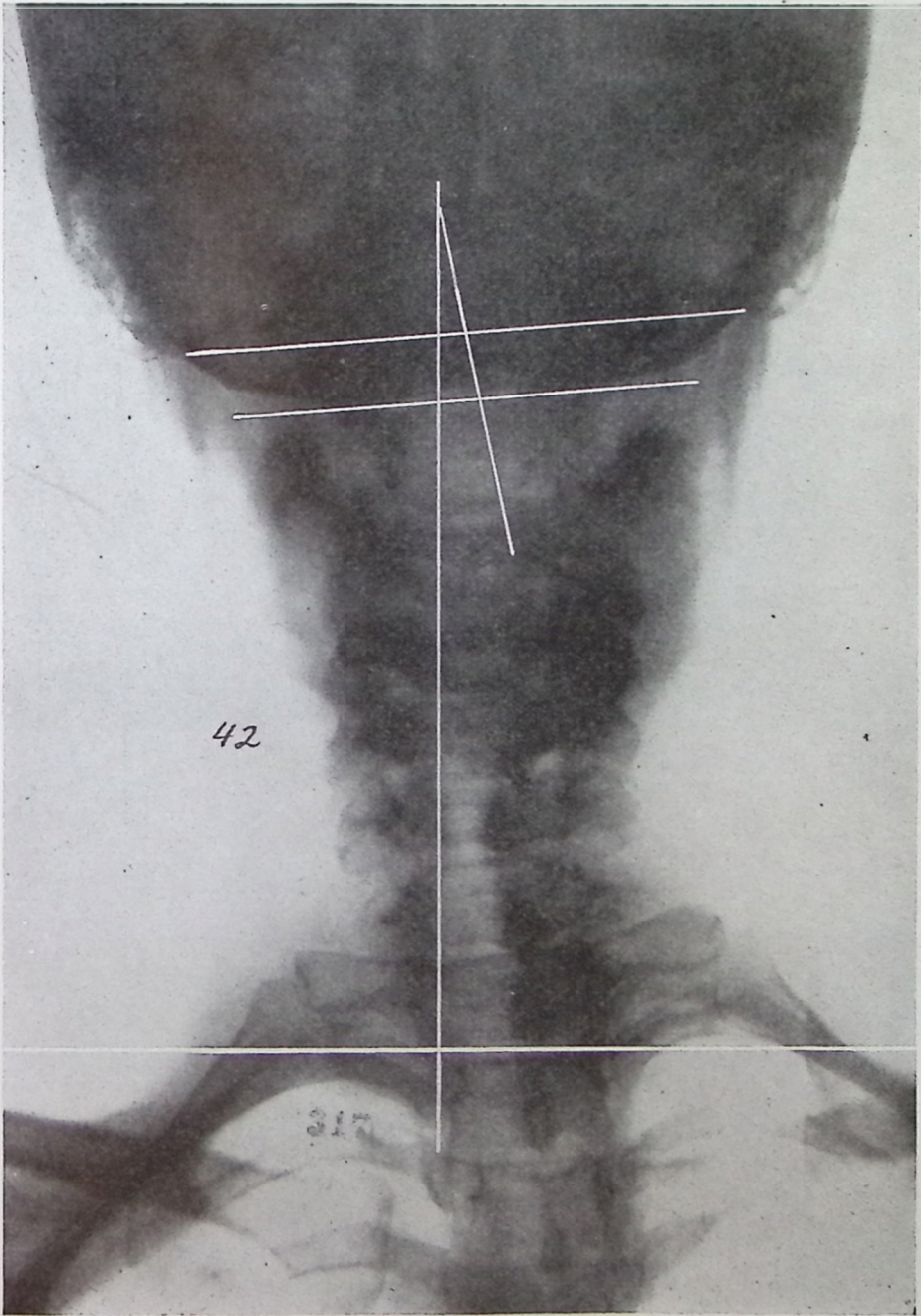


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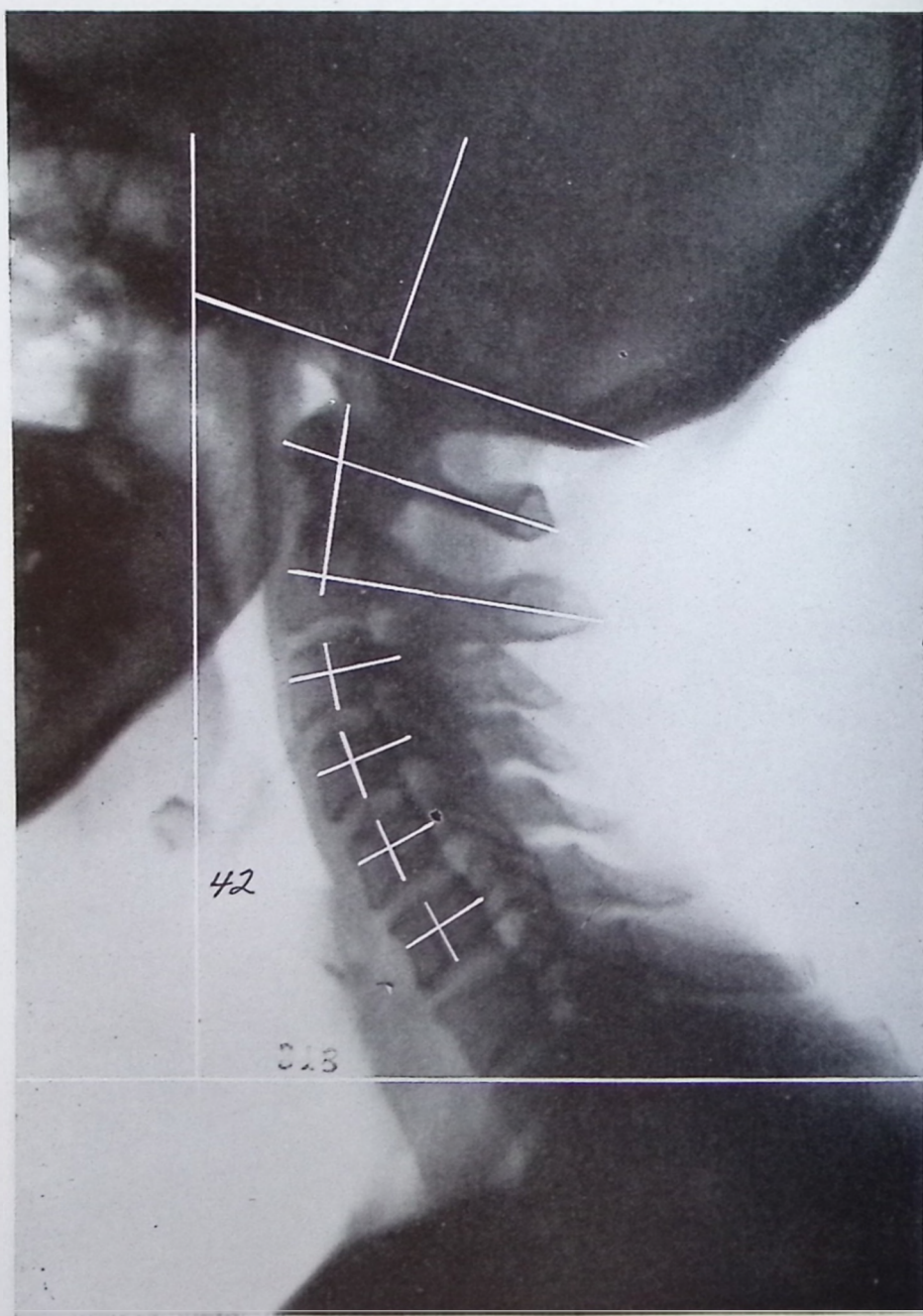


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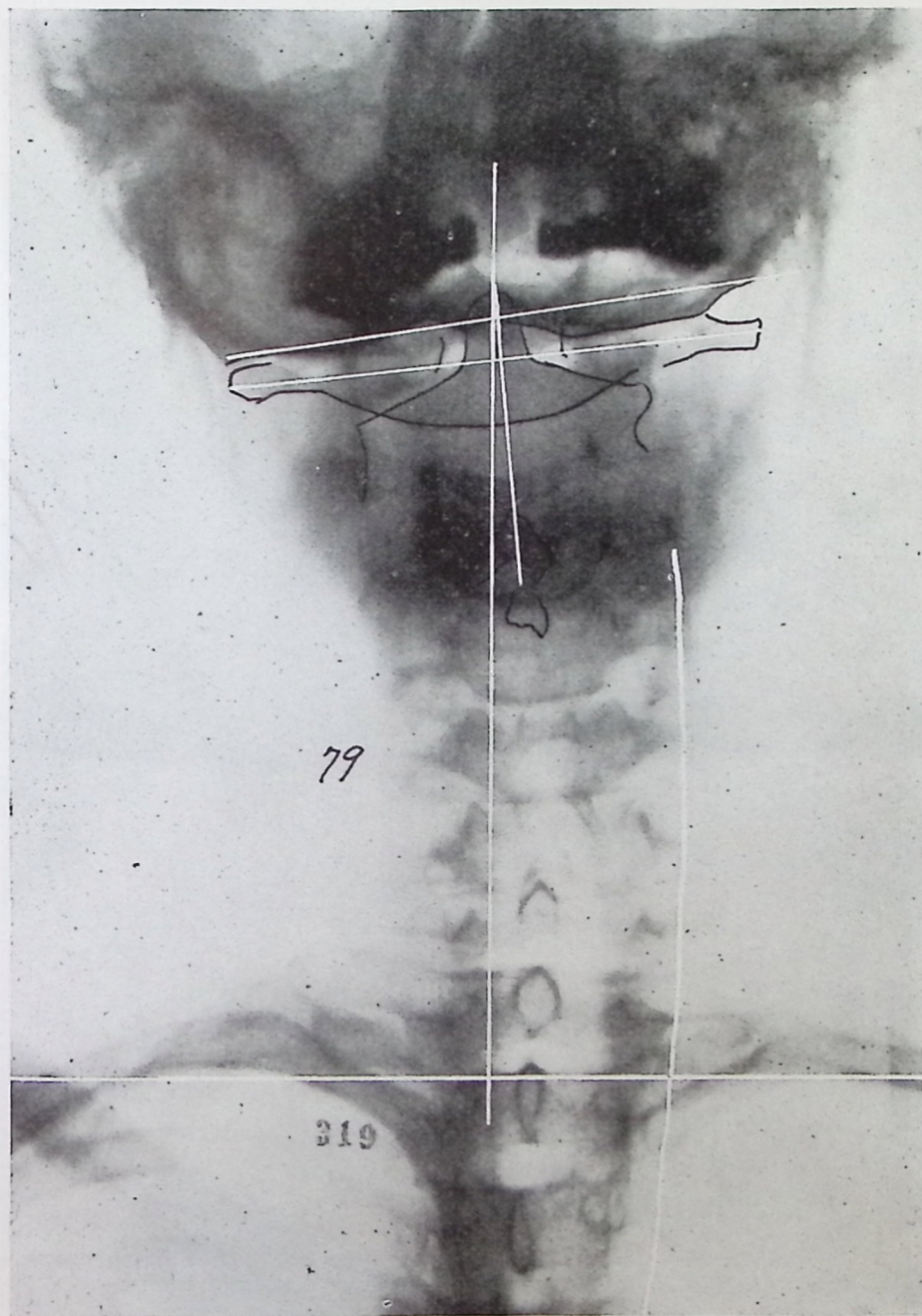


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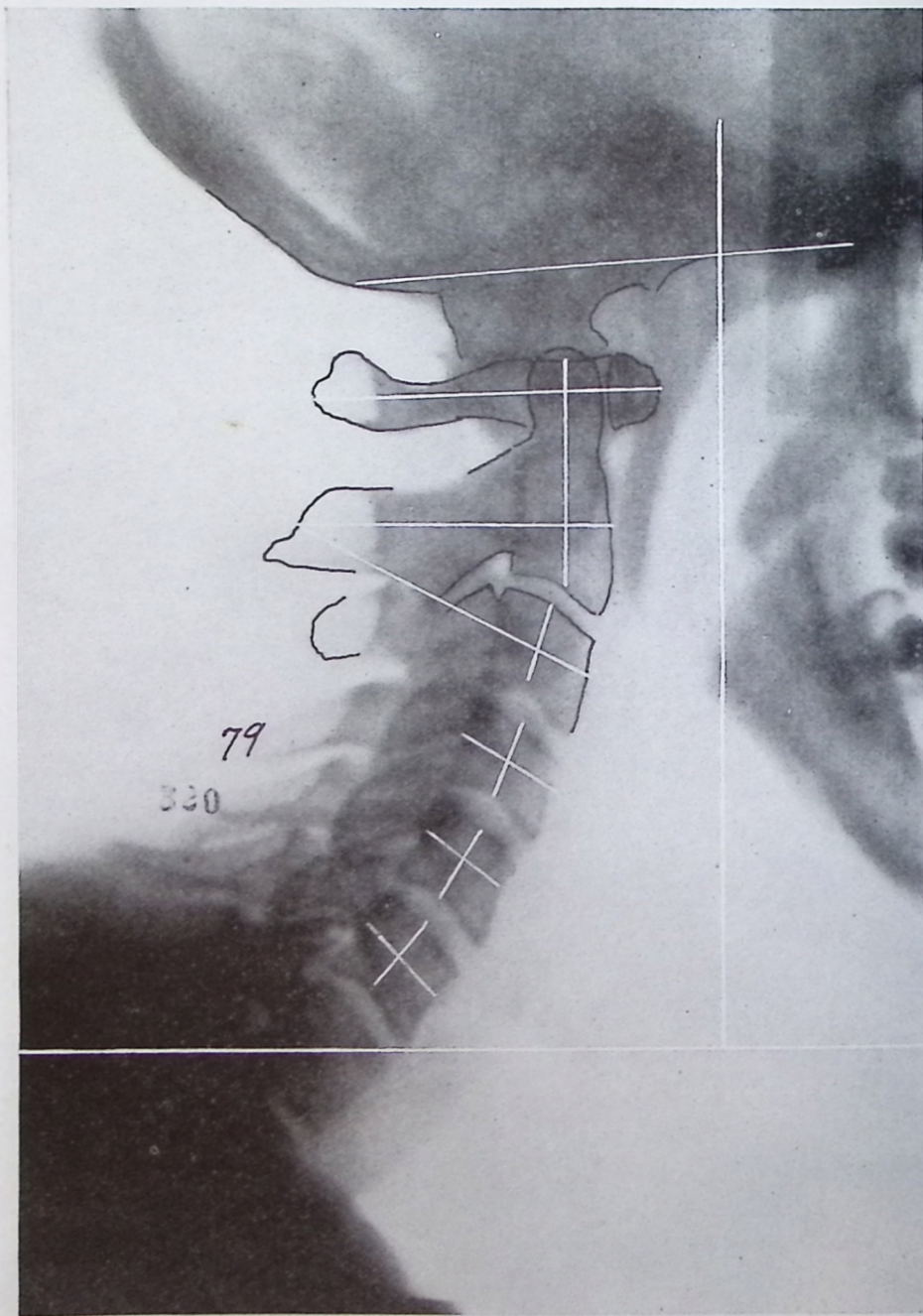


Illustration No. 320



Illustration No. 321

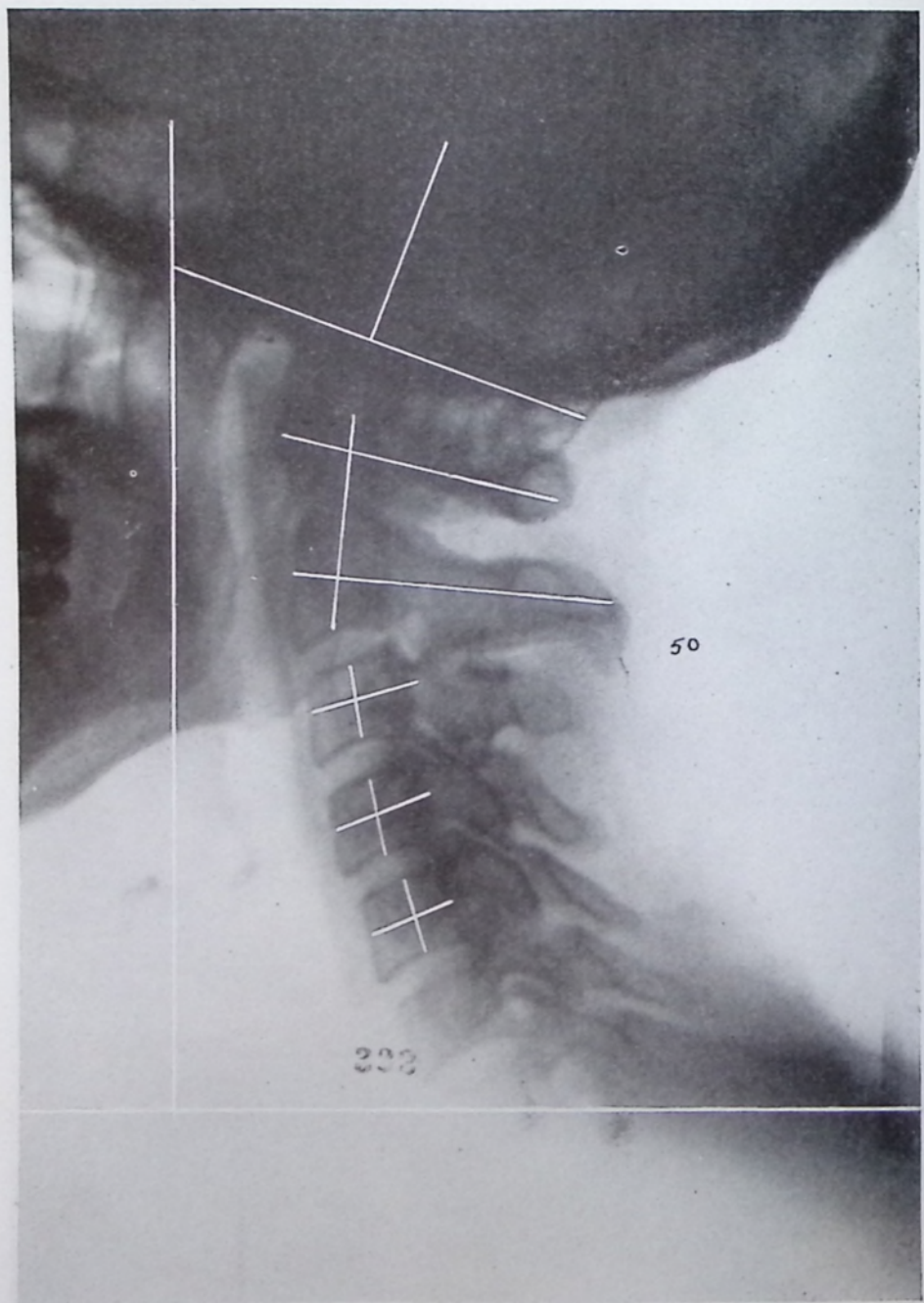


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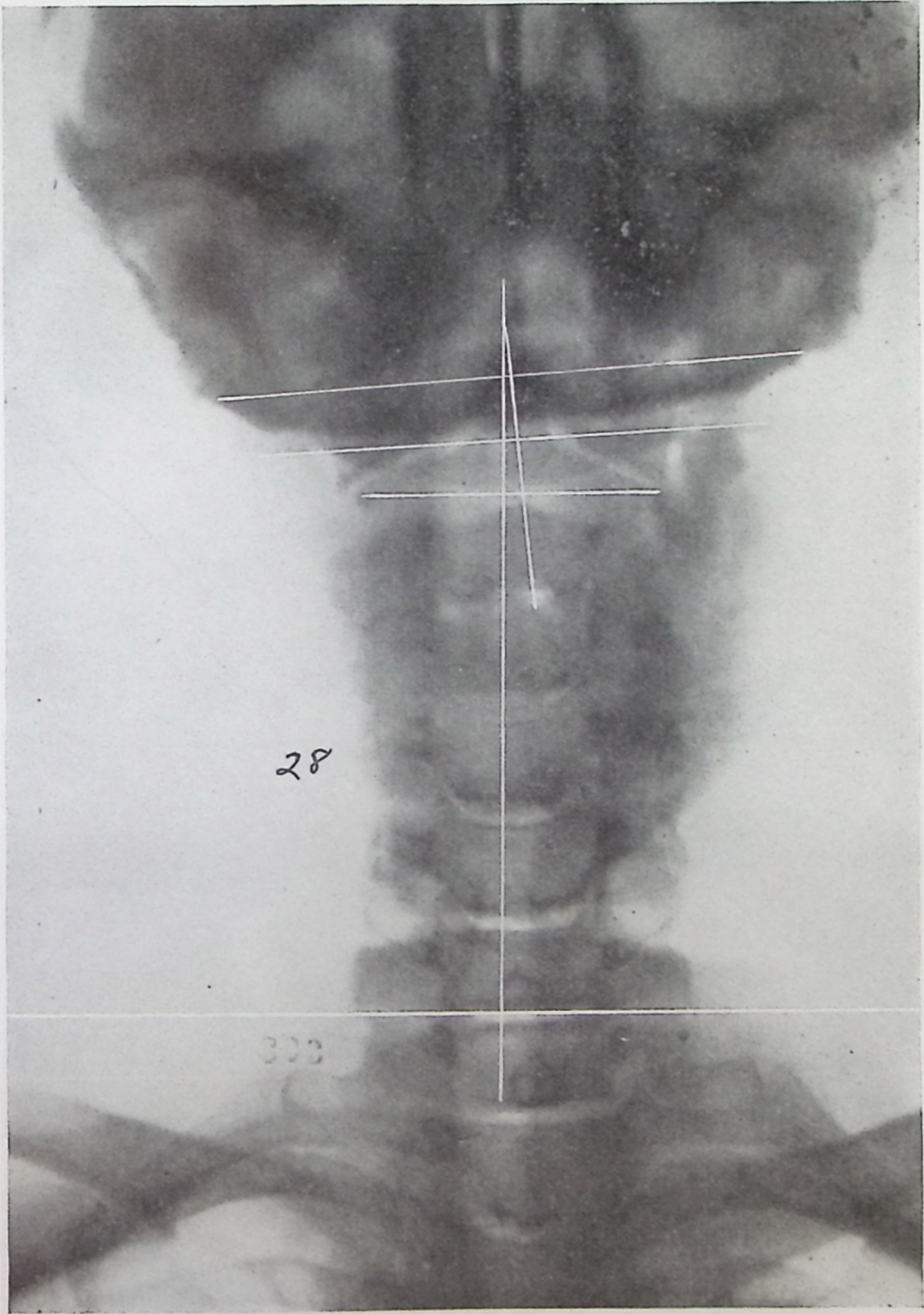


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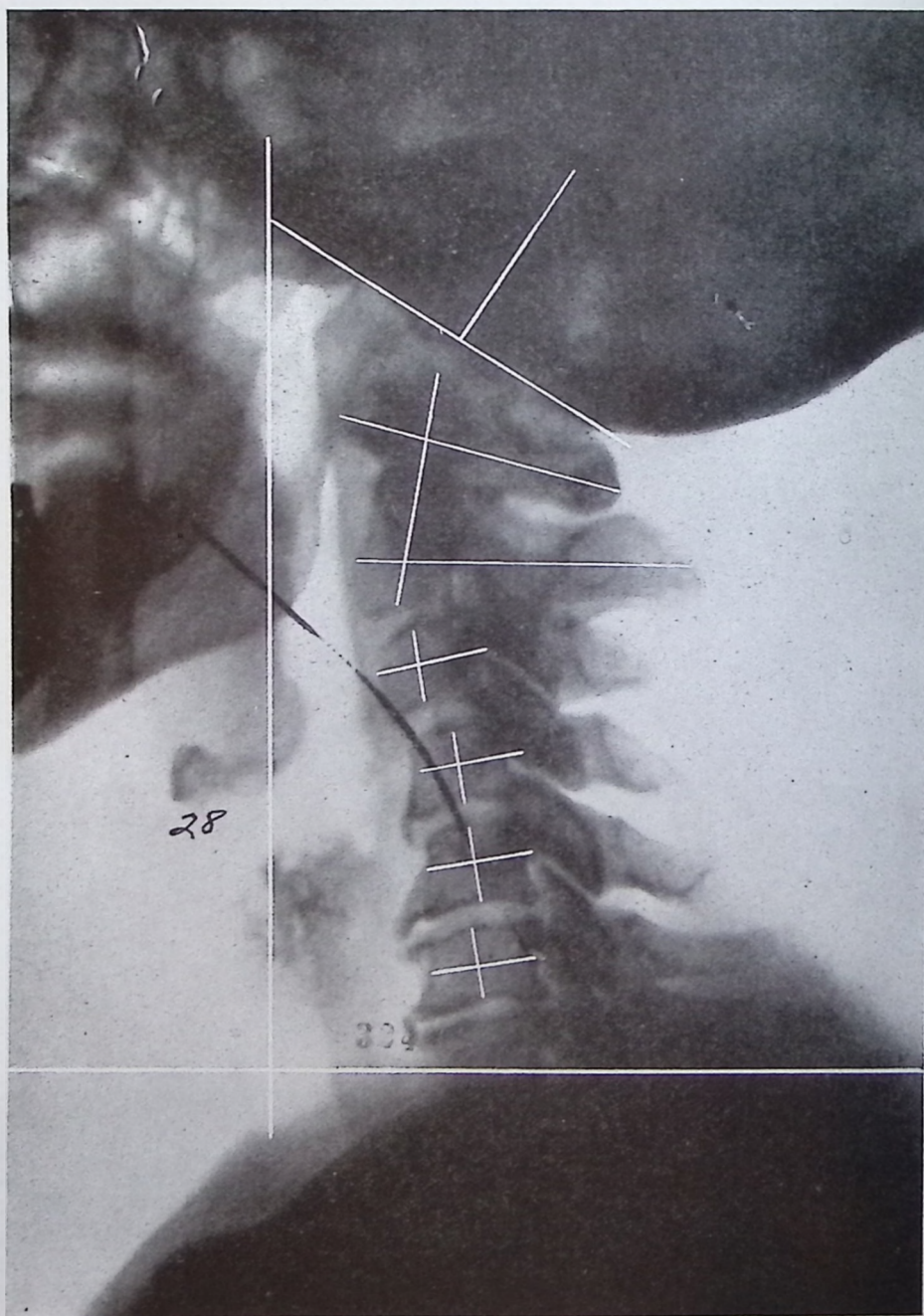


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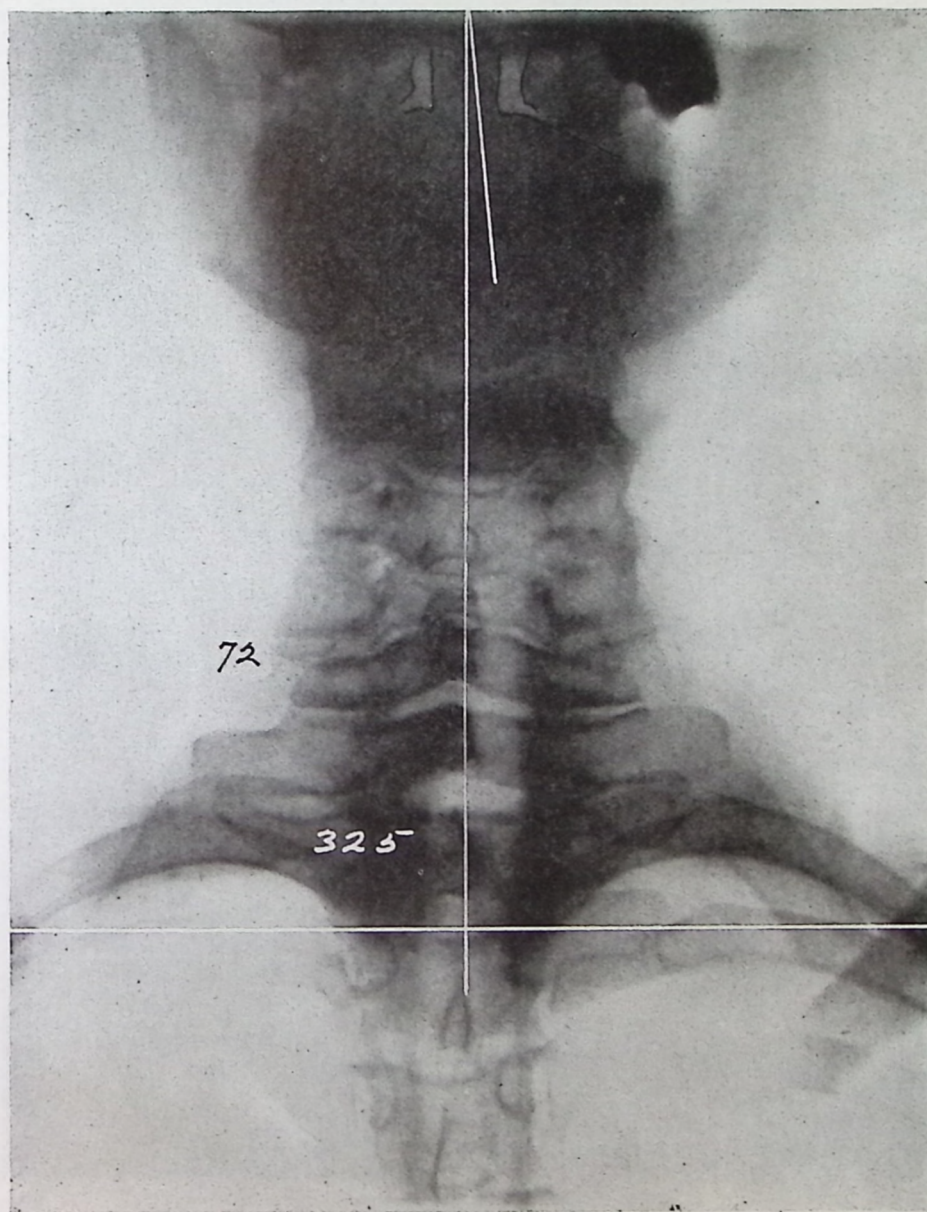


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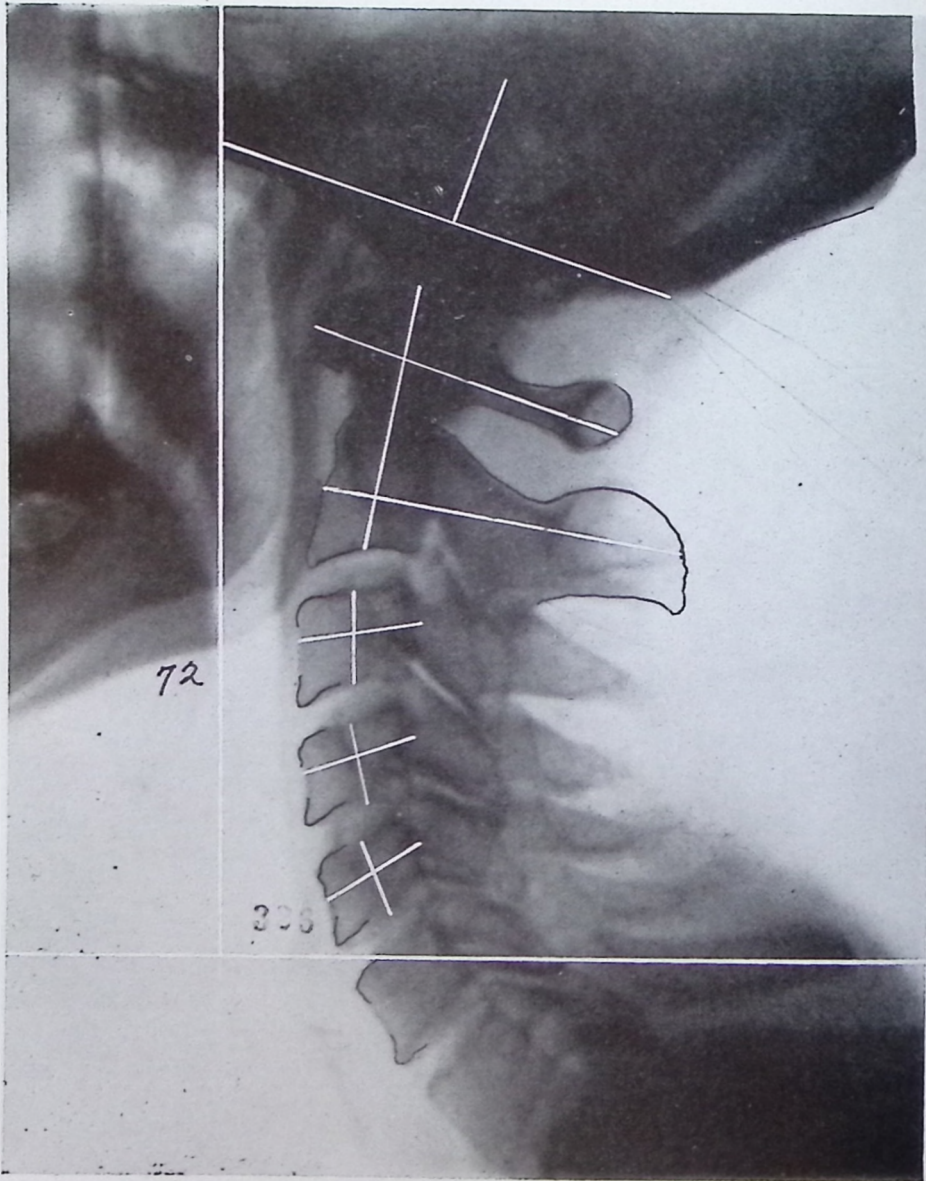


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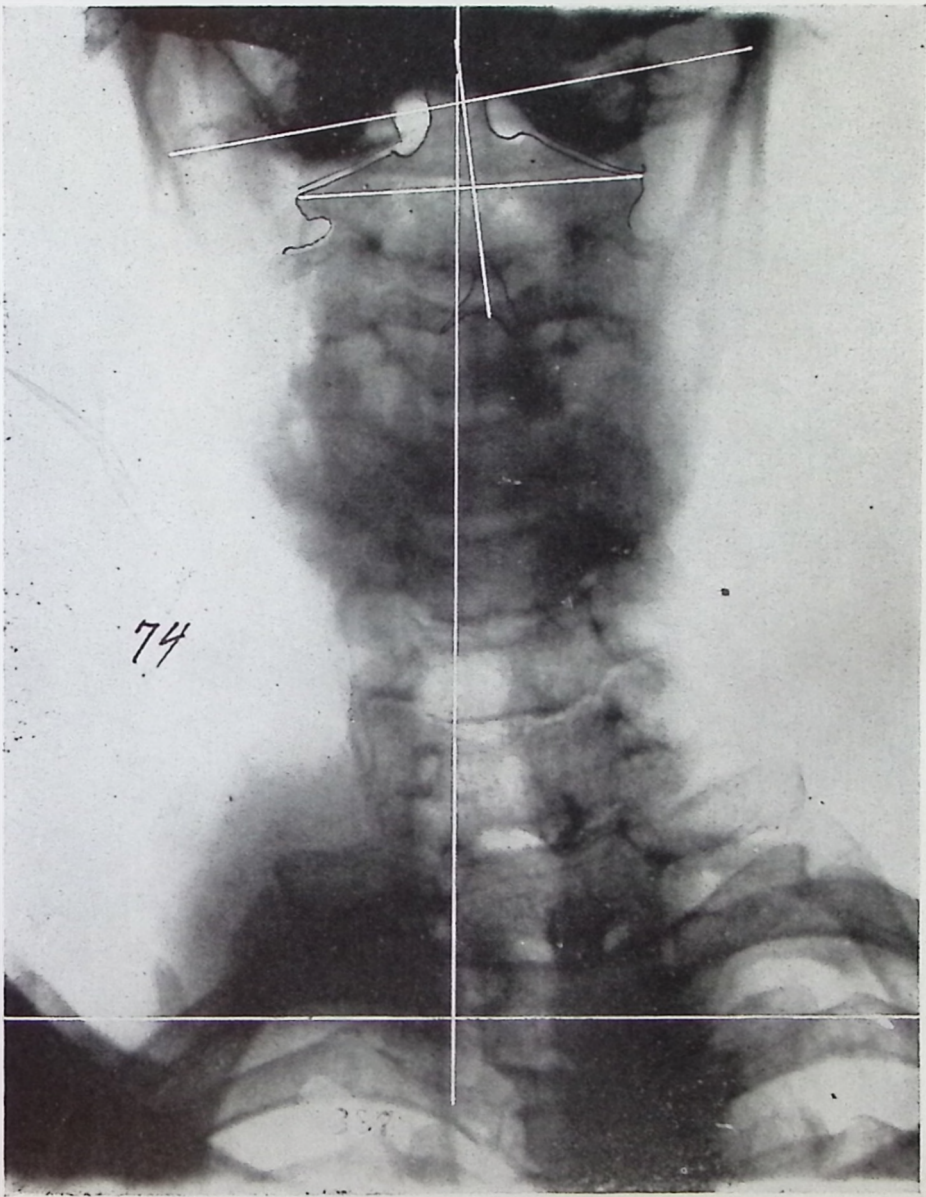


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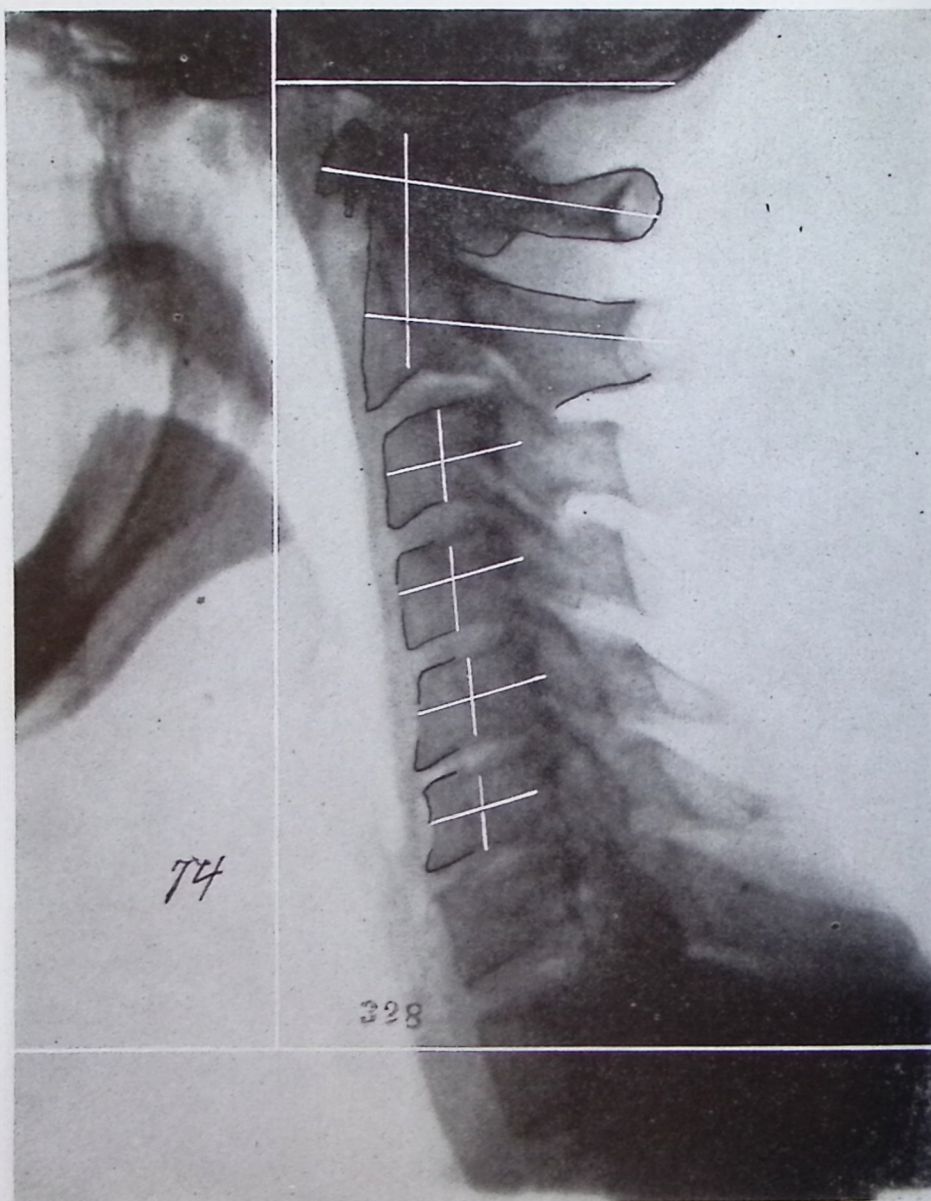


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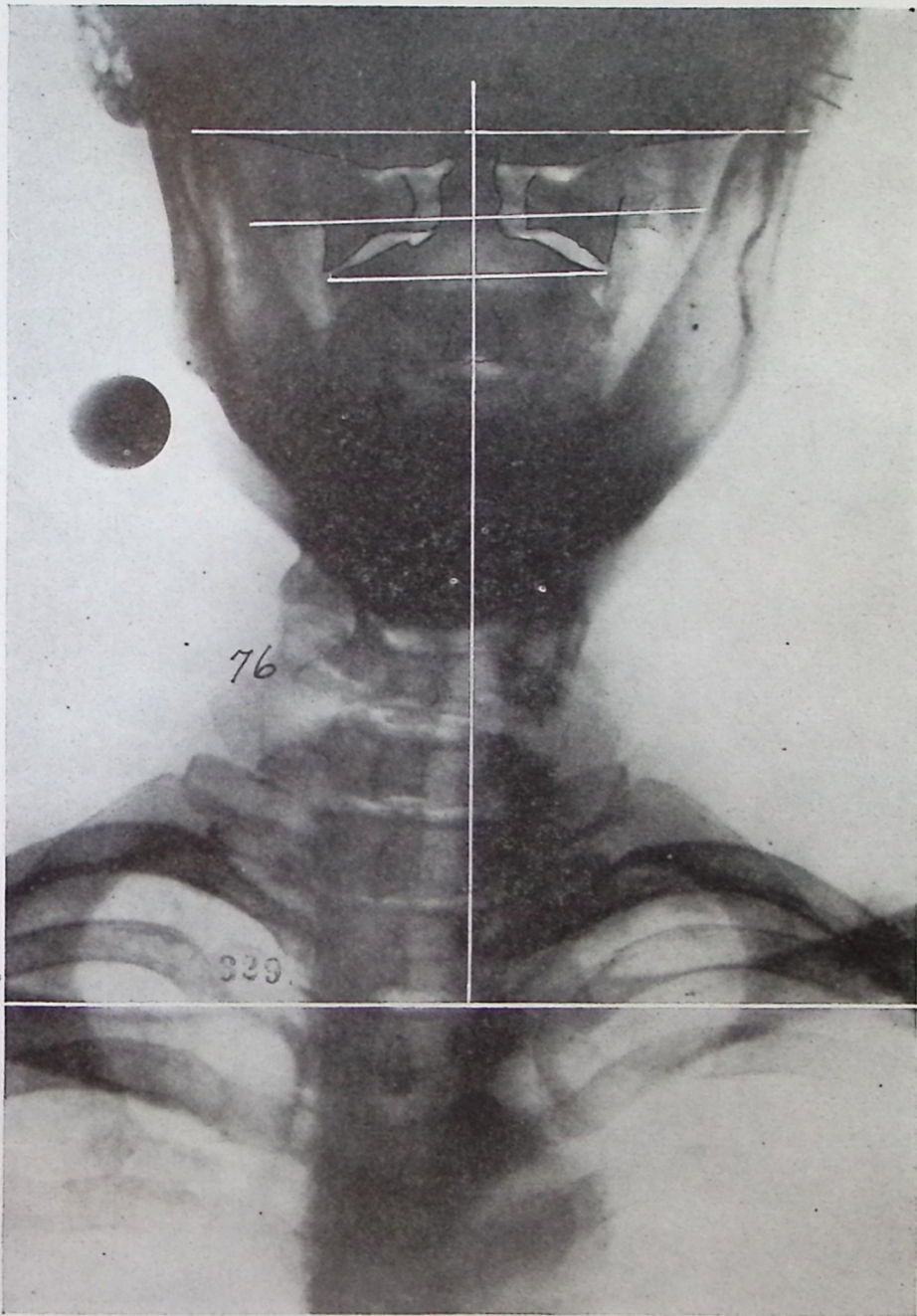


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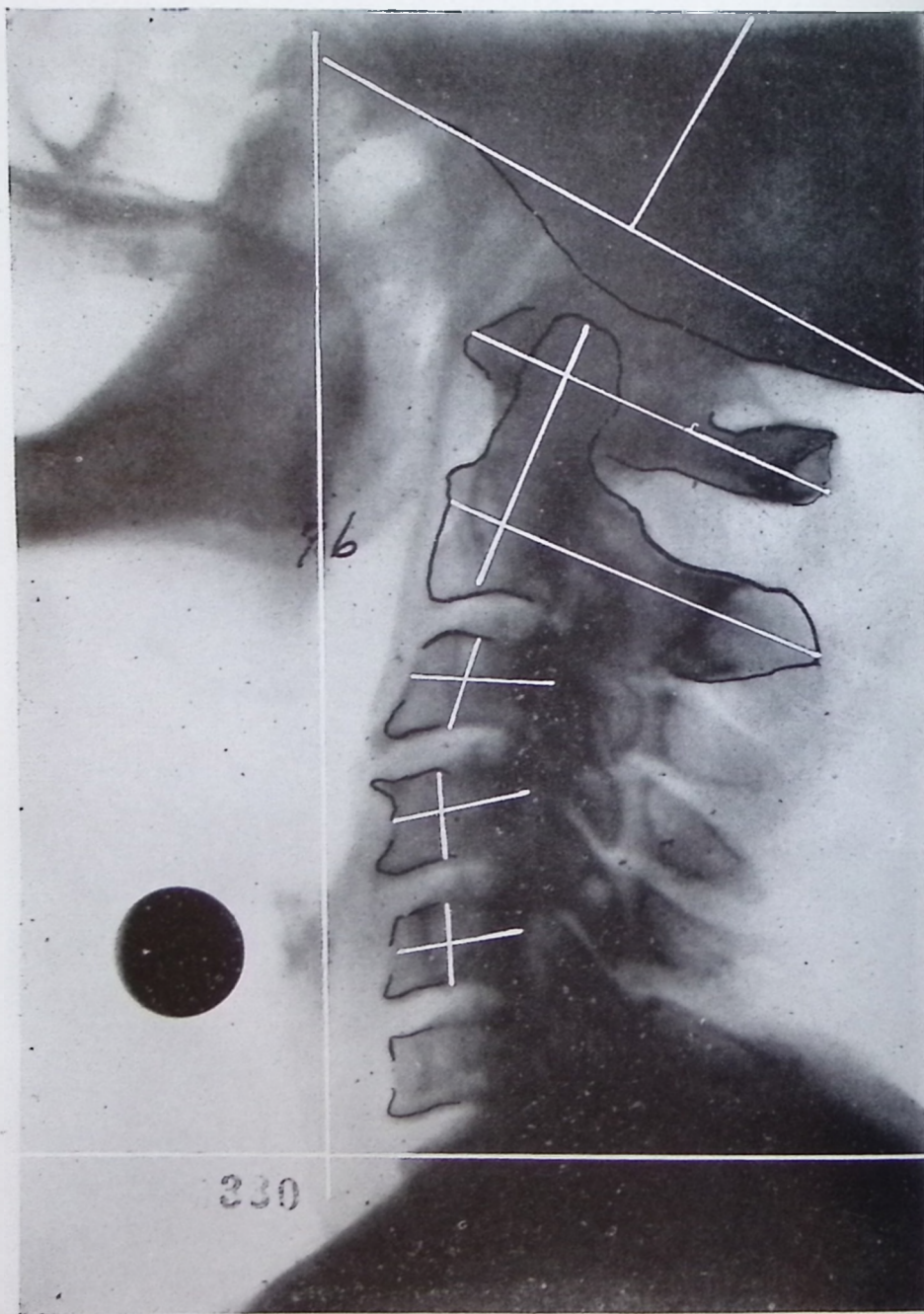


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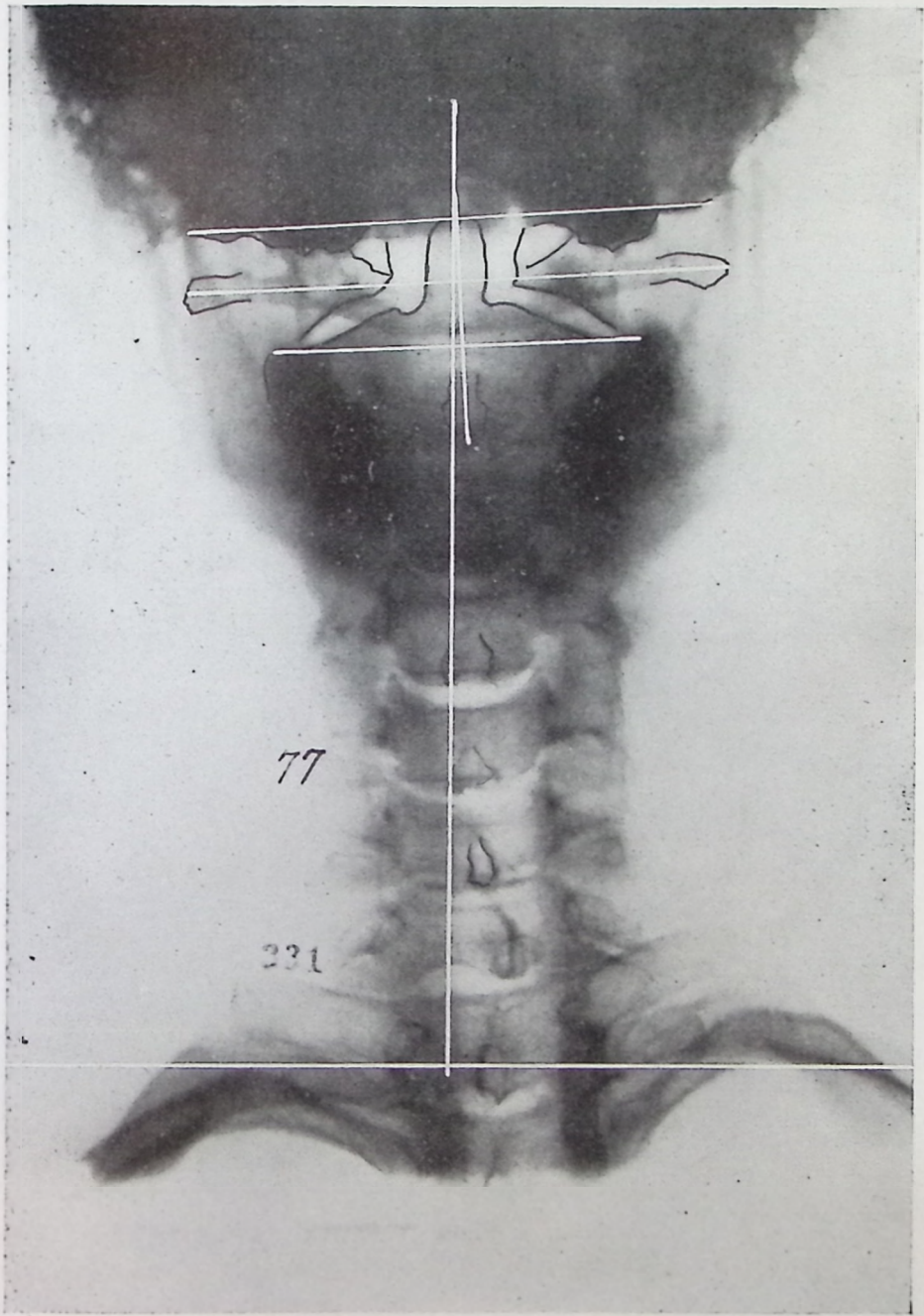


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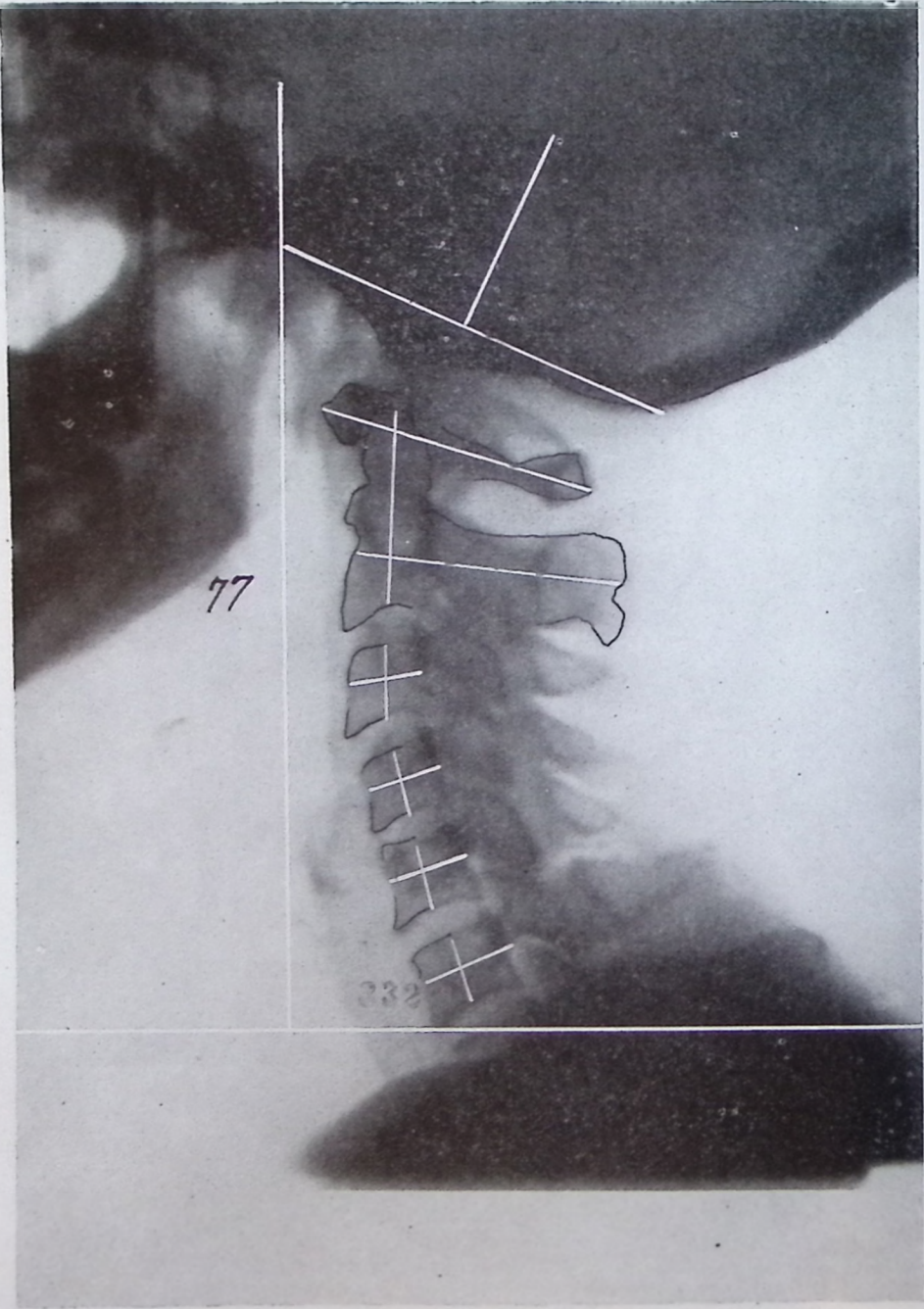


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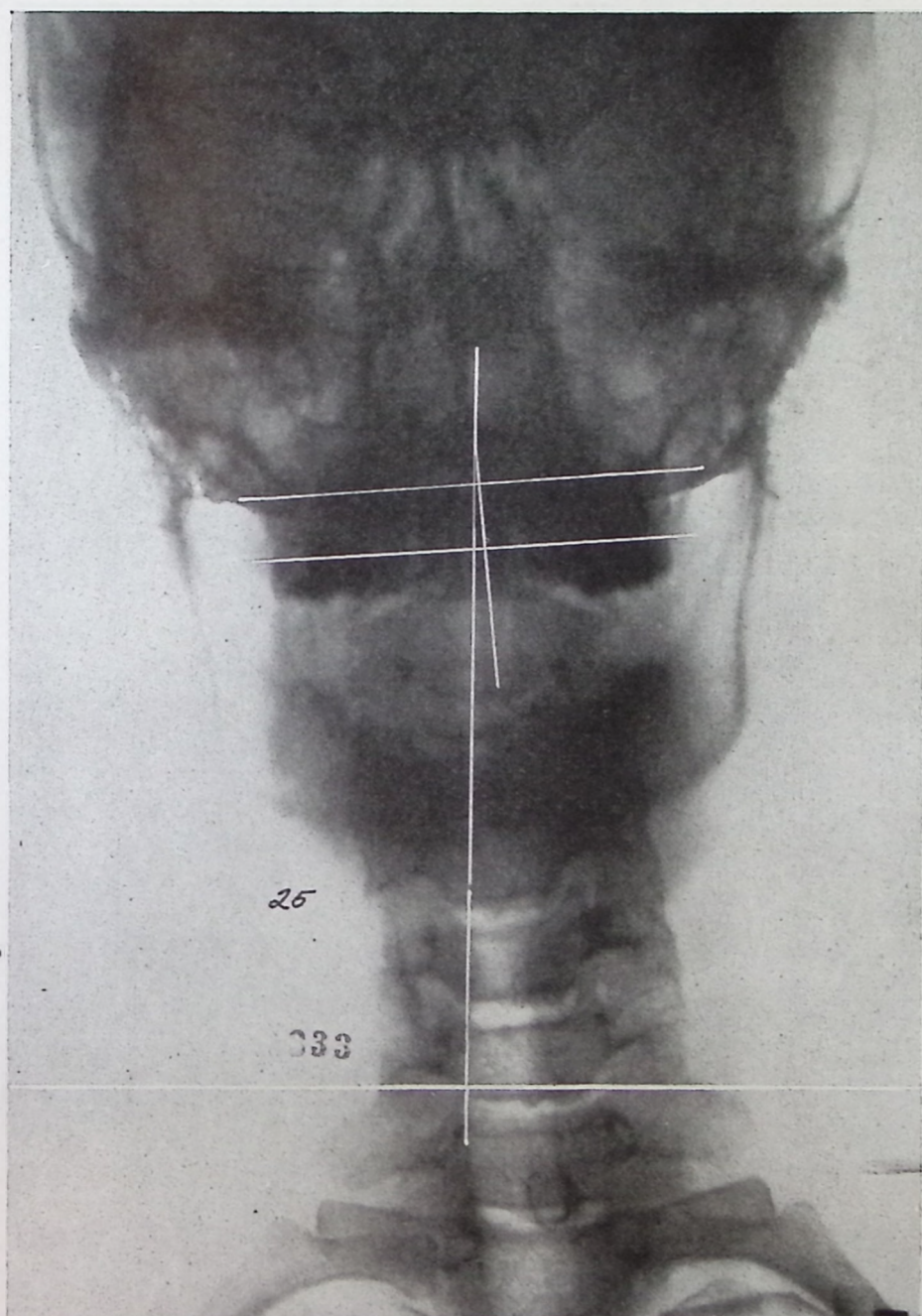
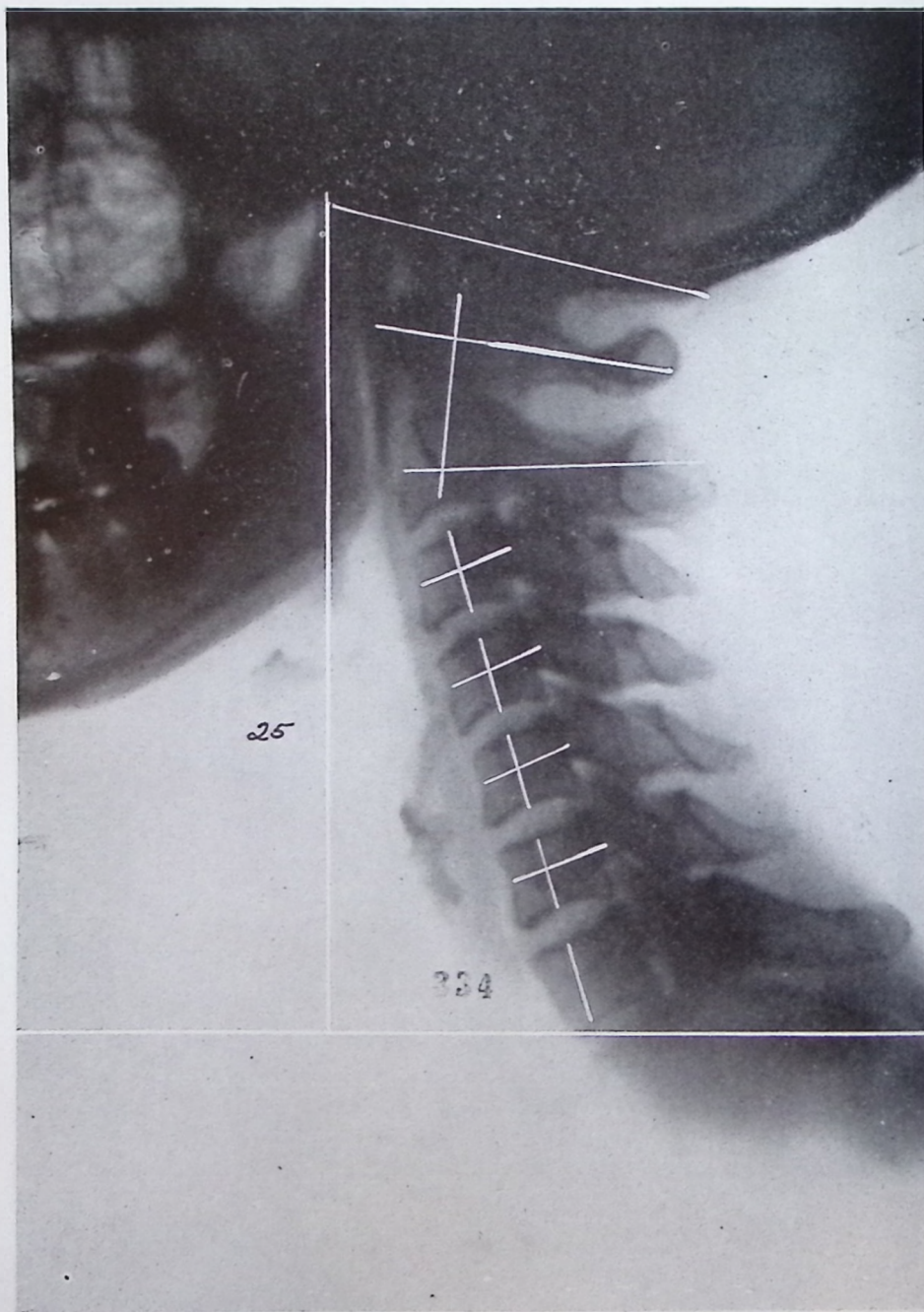


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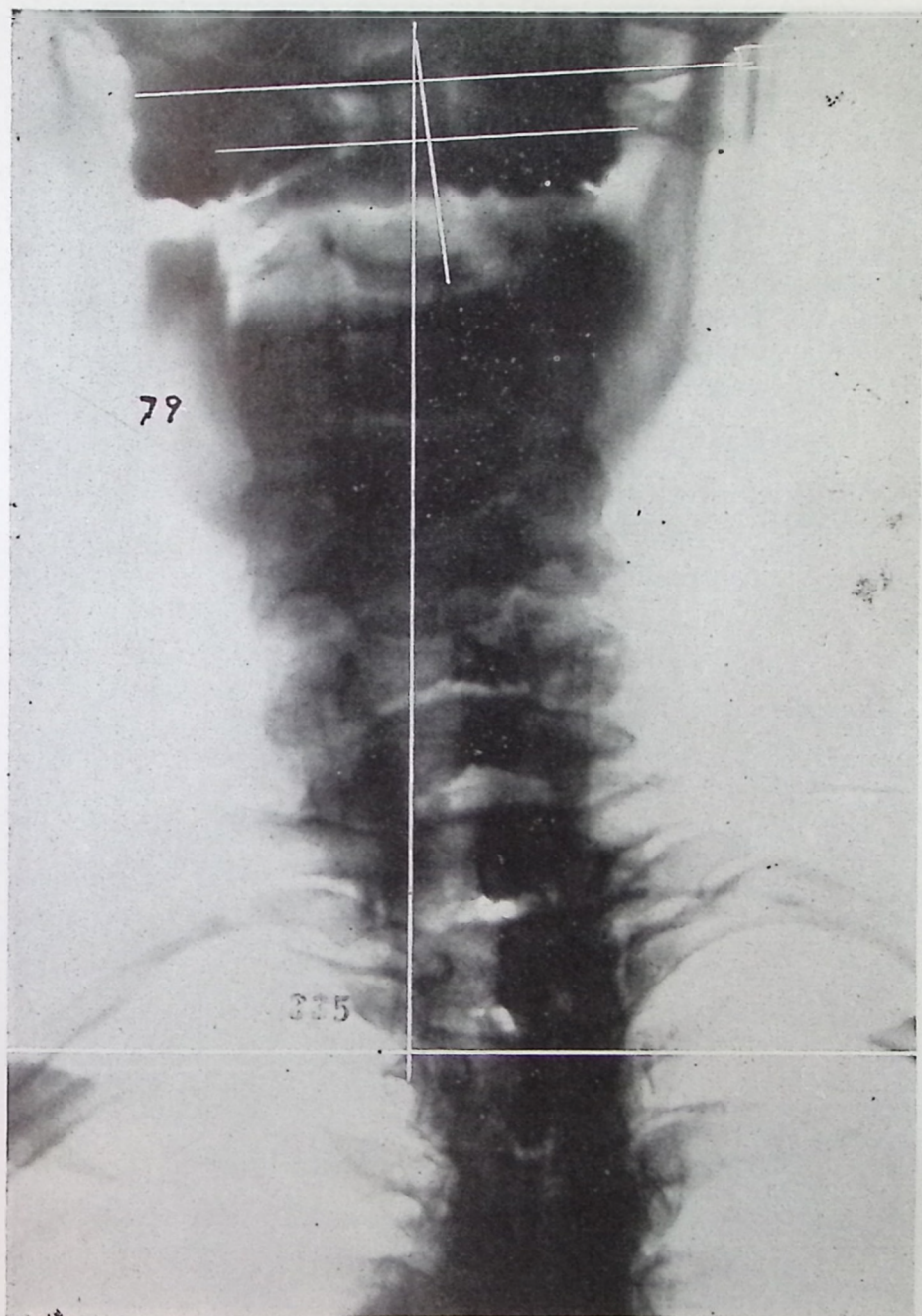


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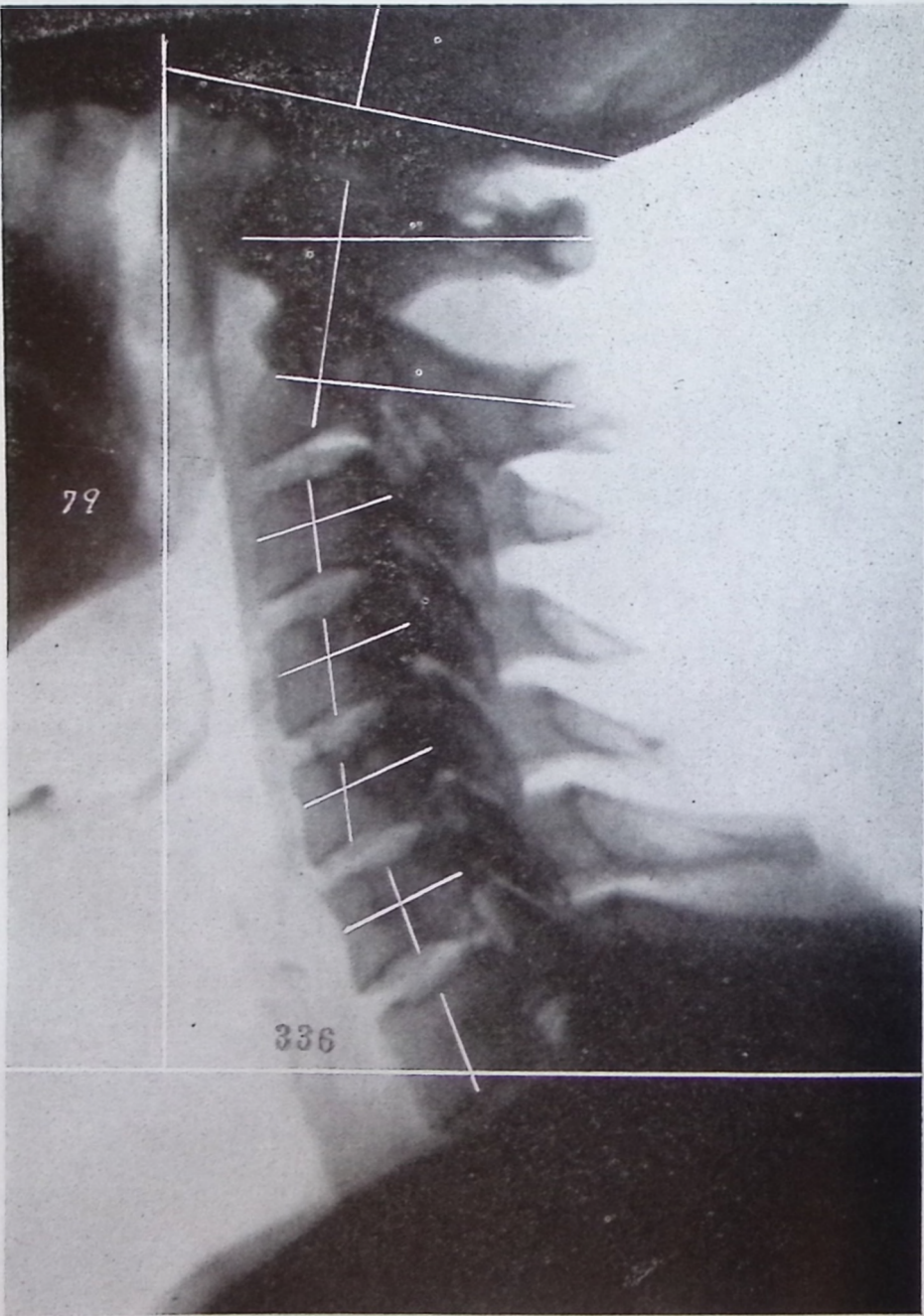


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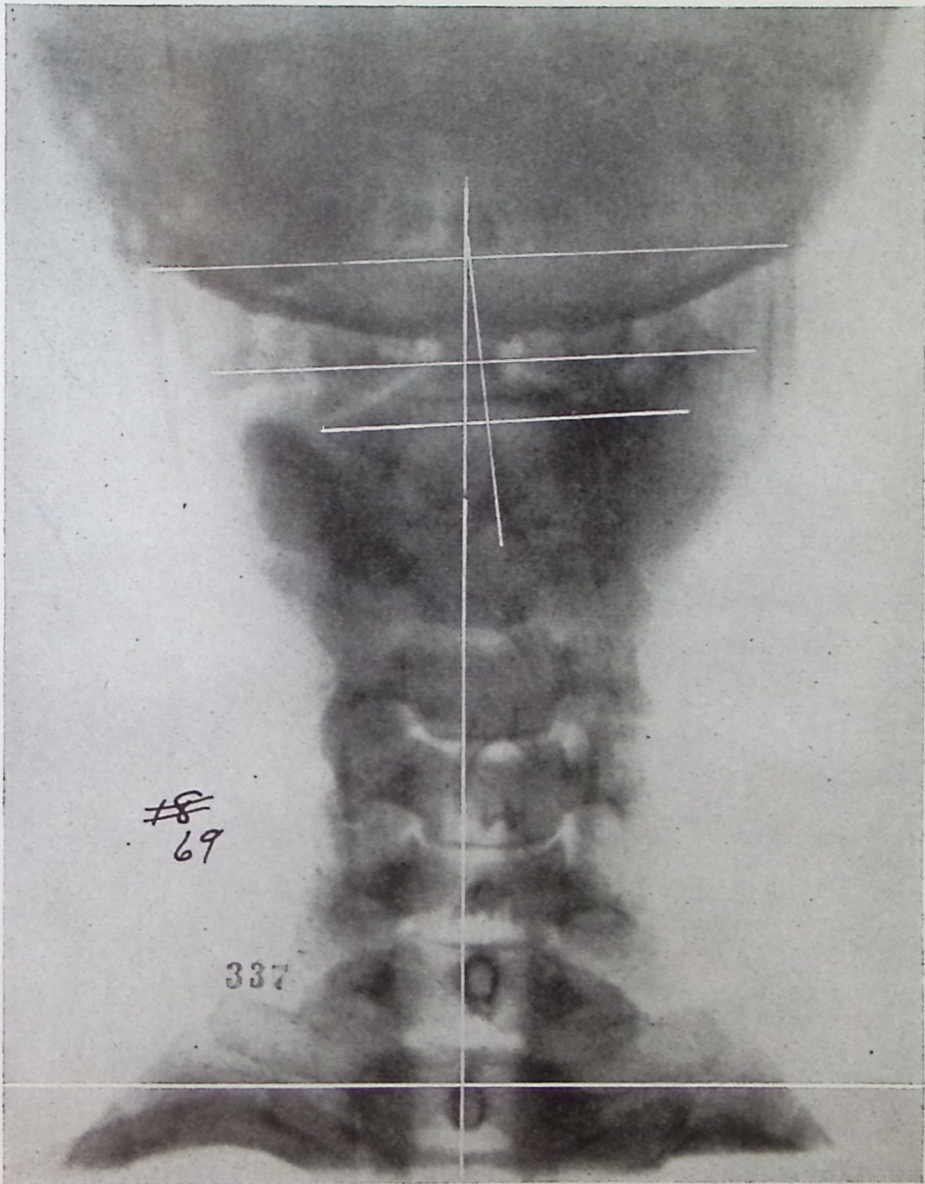


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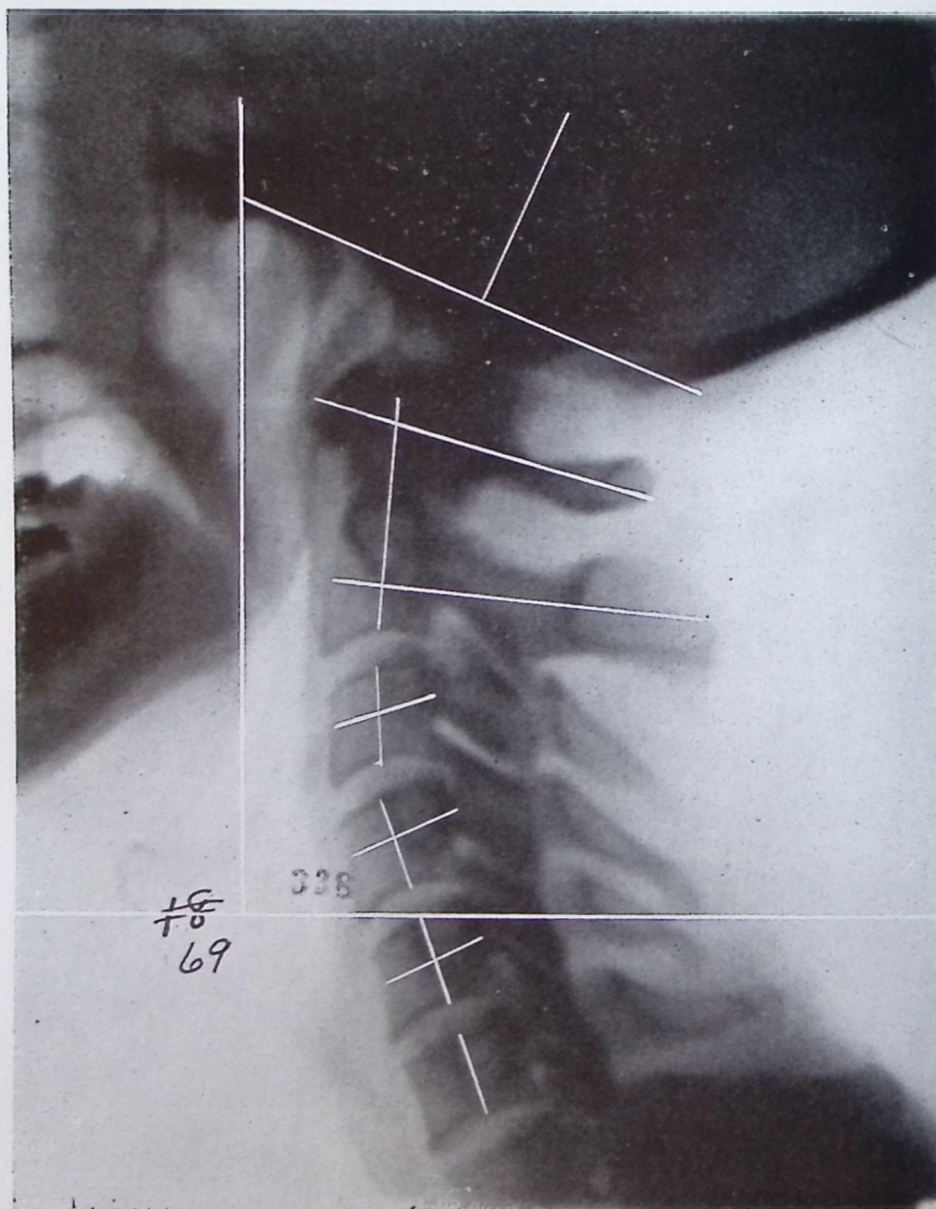


Illustration No. 338



Illustration No. 339

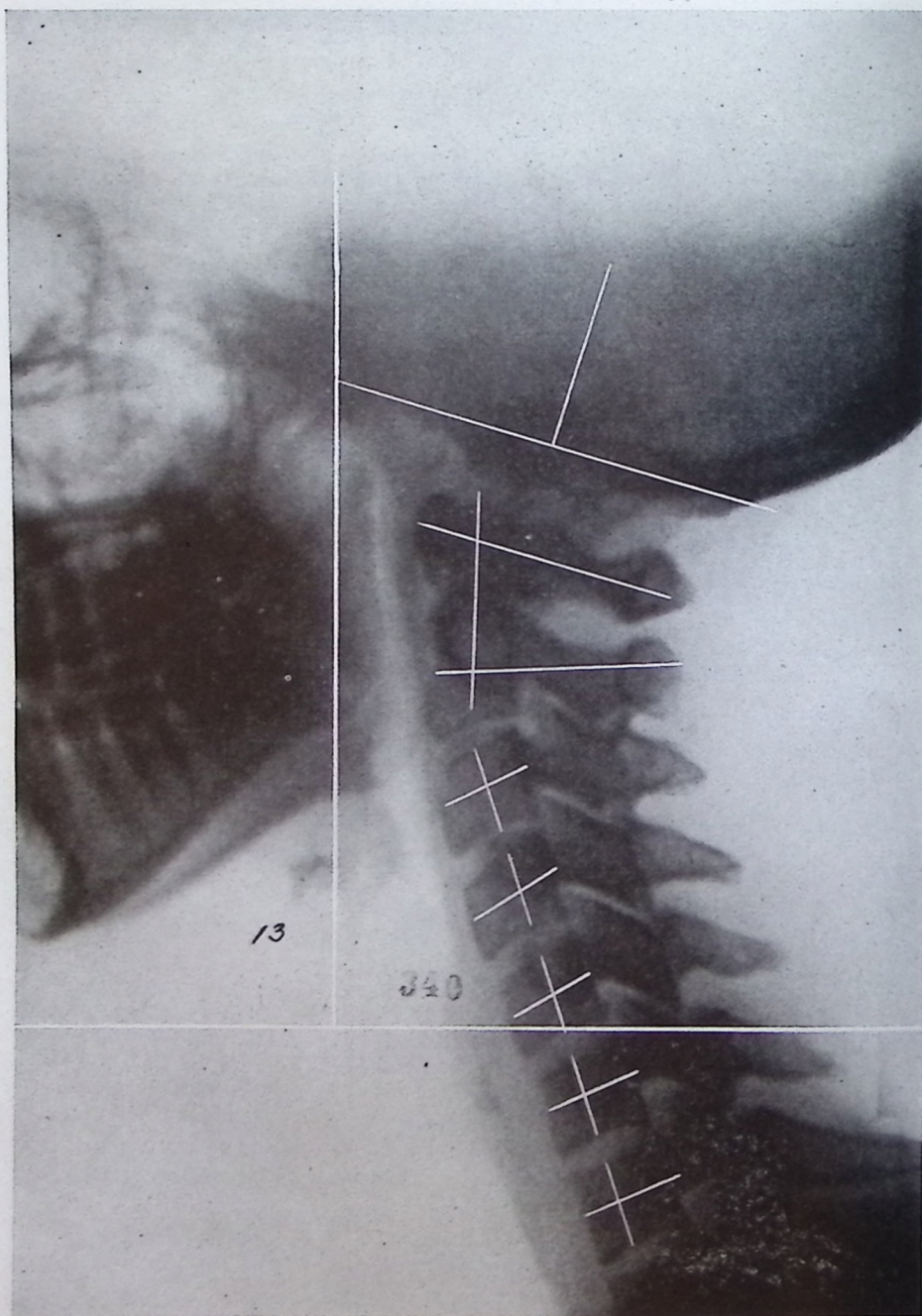


Illustration No. 340

CHAPTER XXXII.

AXIS PLI FALSE SUBLUXATION PLANE LINES.

Illustrations No. 349 to No- 350

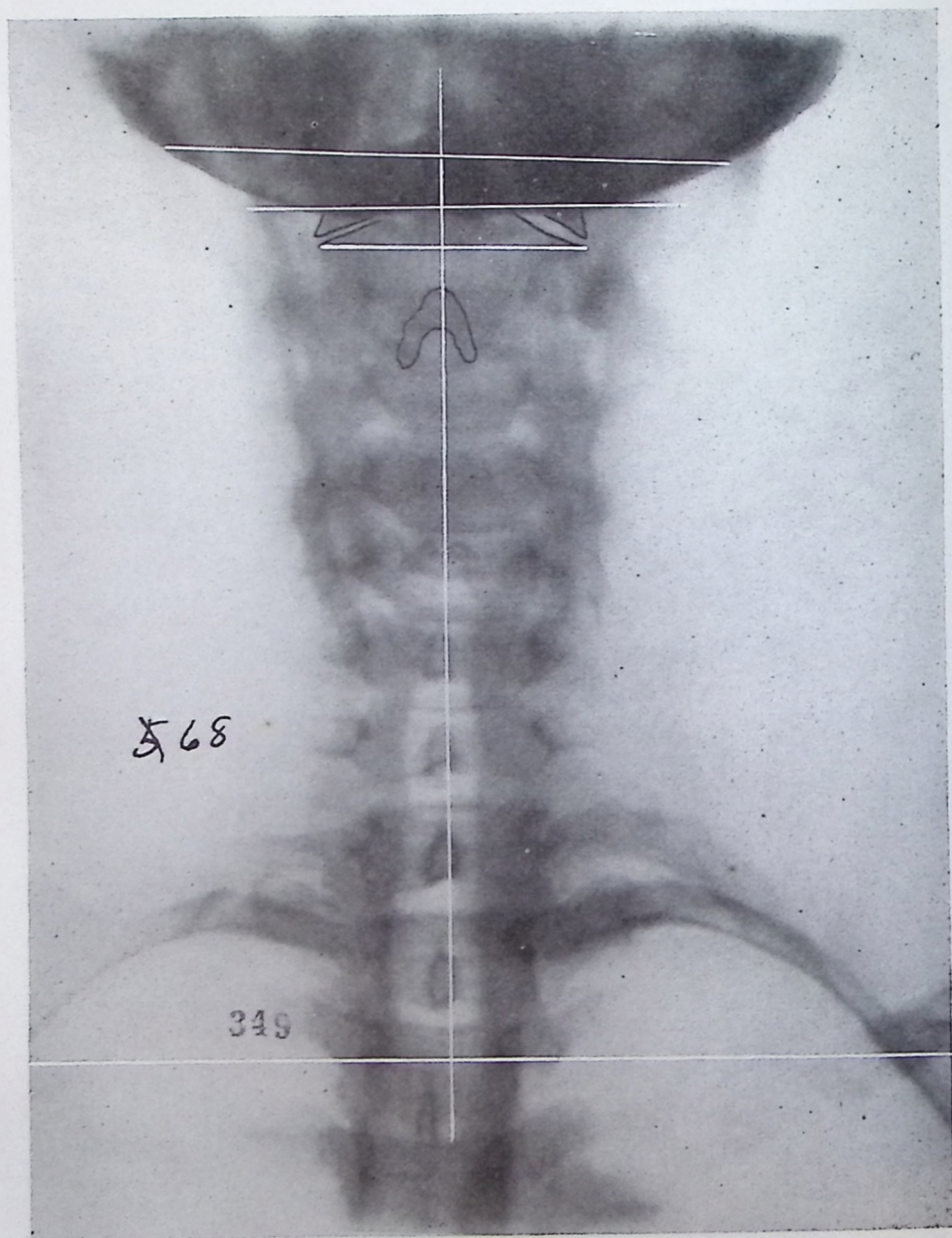


Illustration No. 349

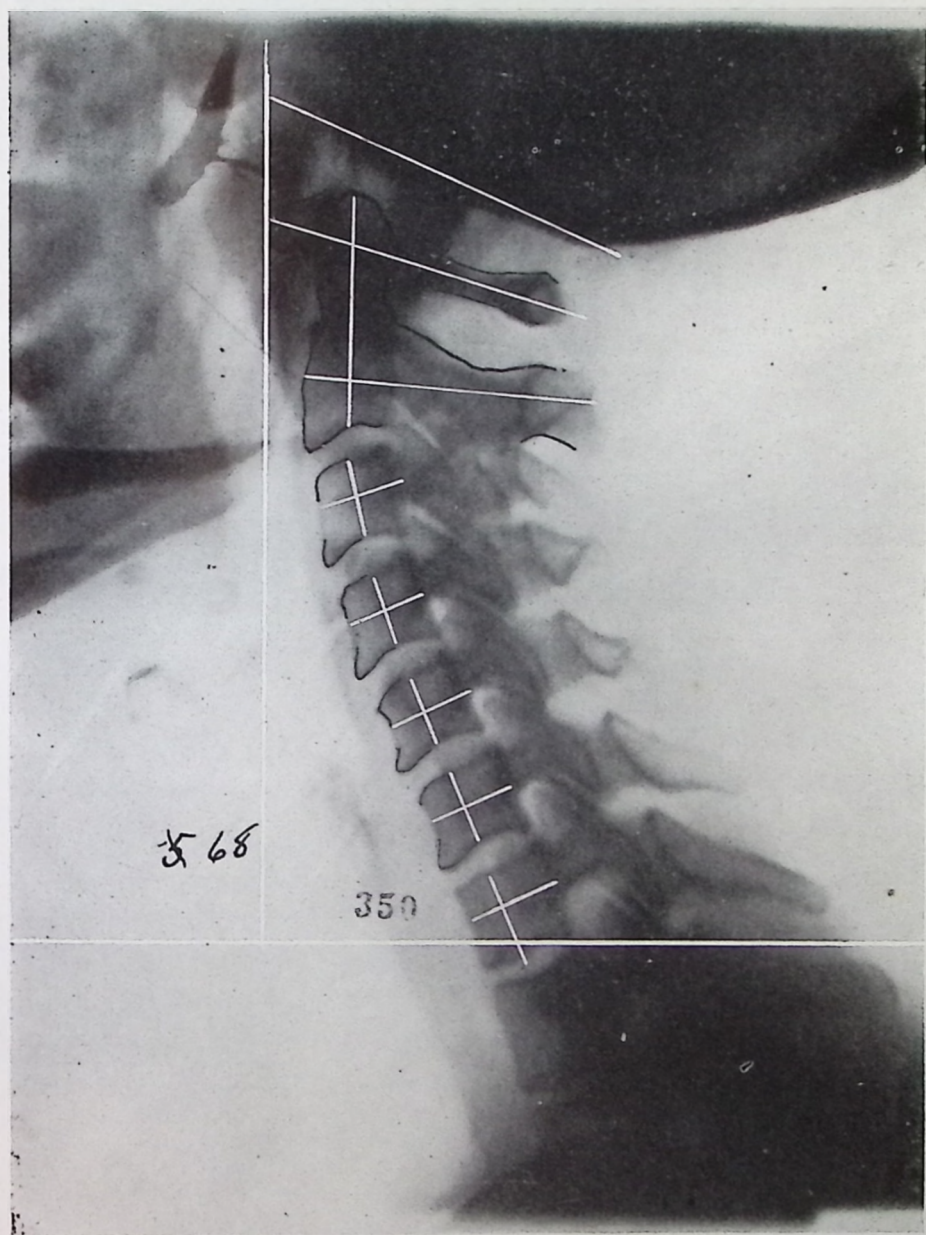


Illustration No. 350

CHAPTER XXXIII.
ATLAS ASR SUBLUXATION PLANE LINES.
Illustrations No. 351 to No. 366

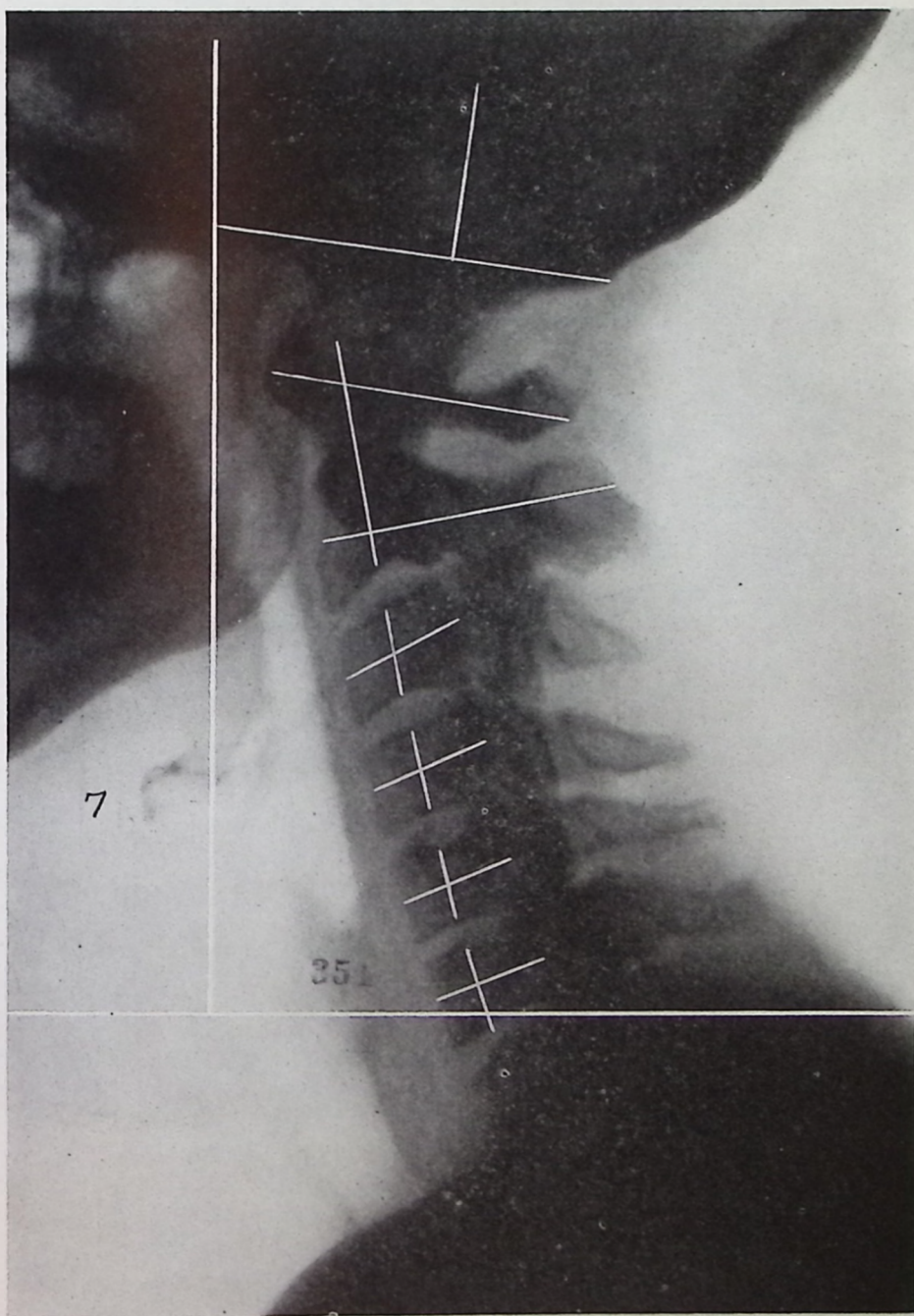


Illustration No. 351



Illustration No. 352

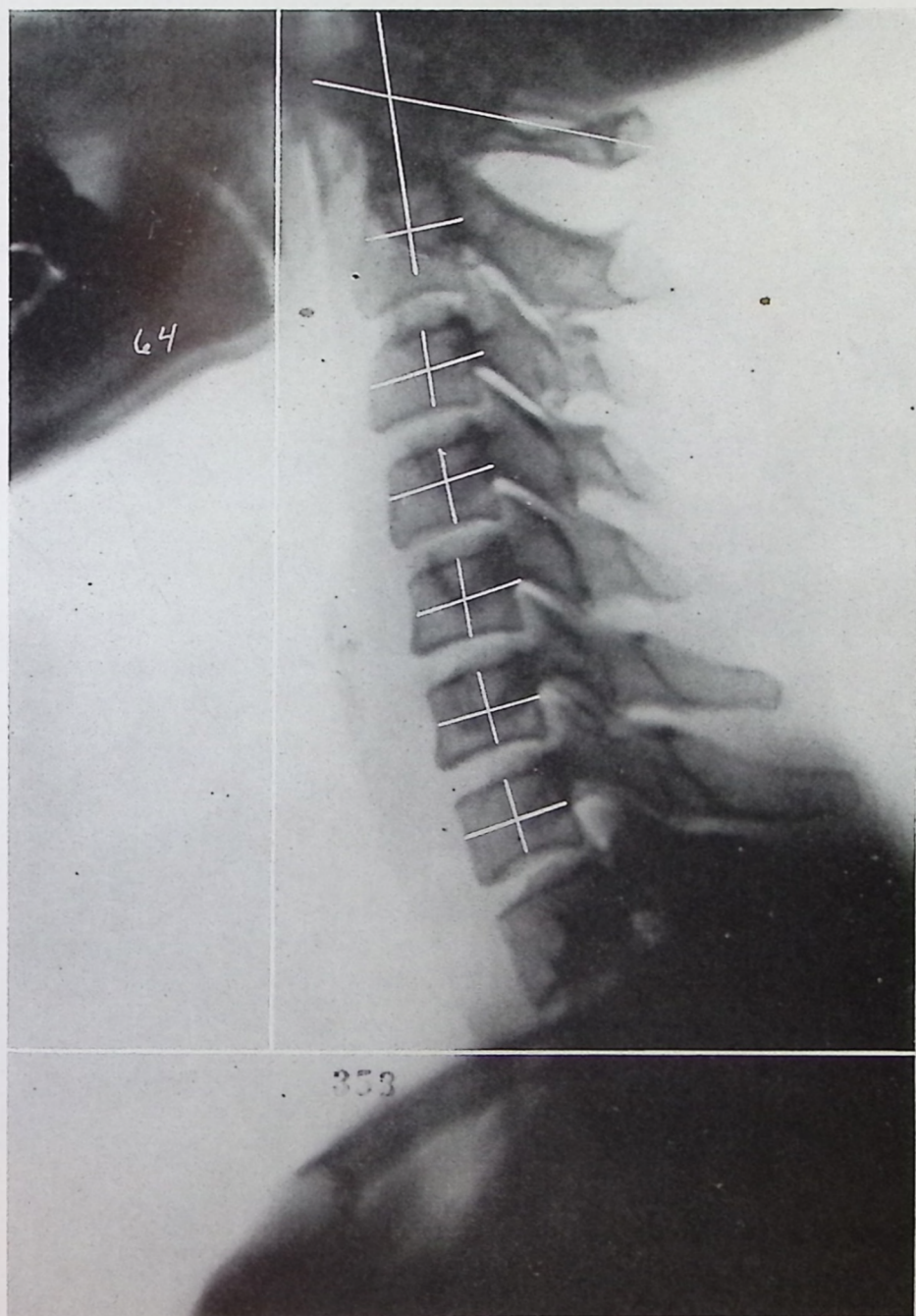


Illustration No. 353

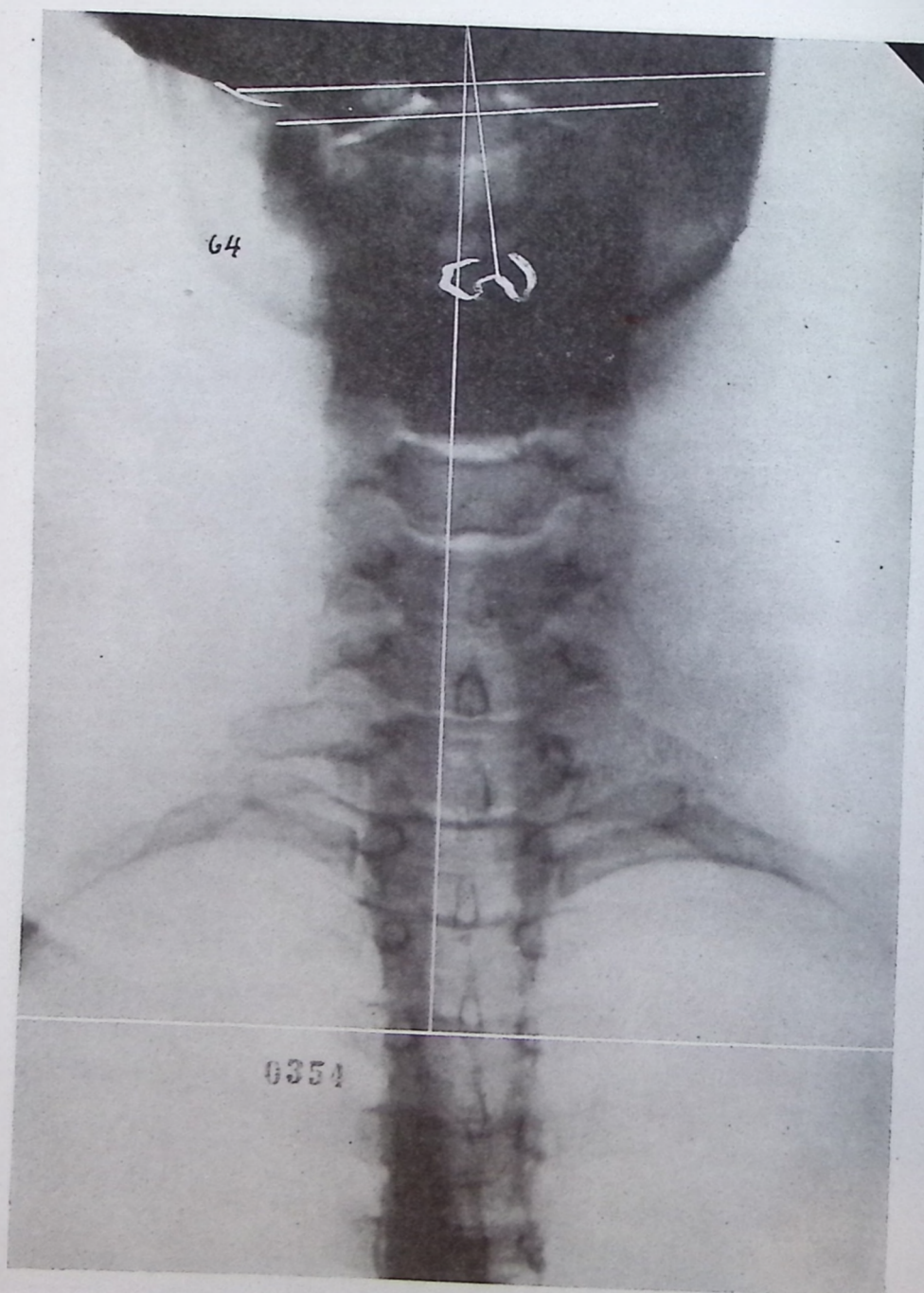


Illustration No. 354

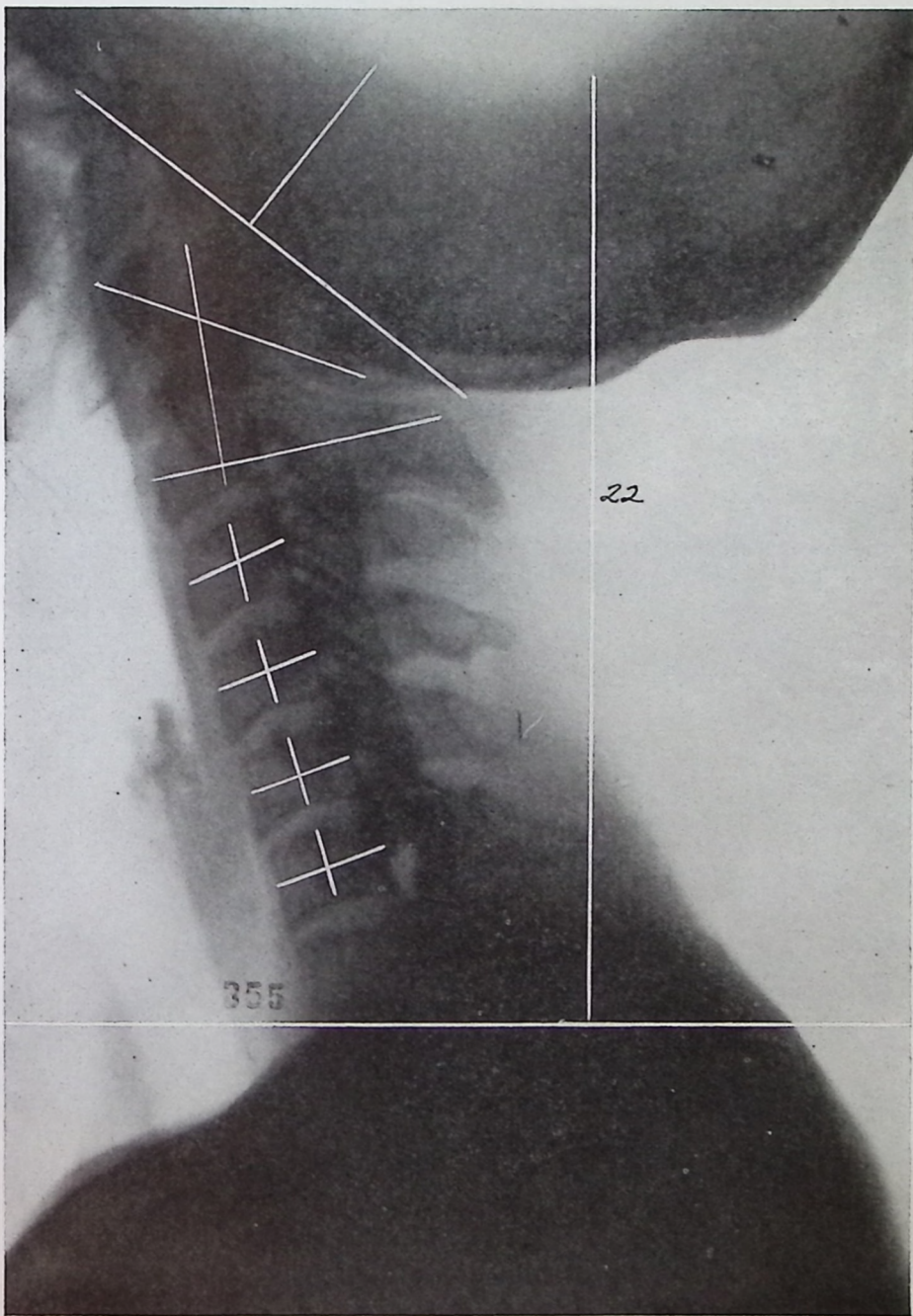


Illustration No. 355

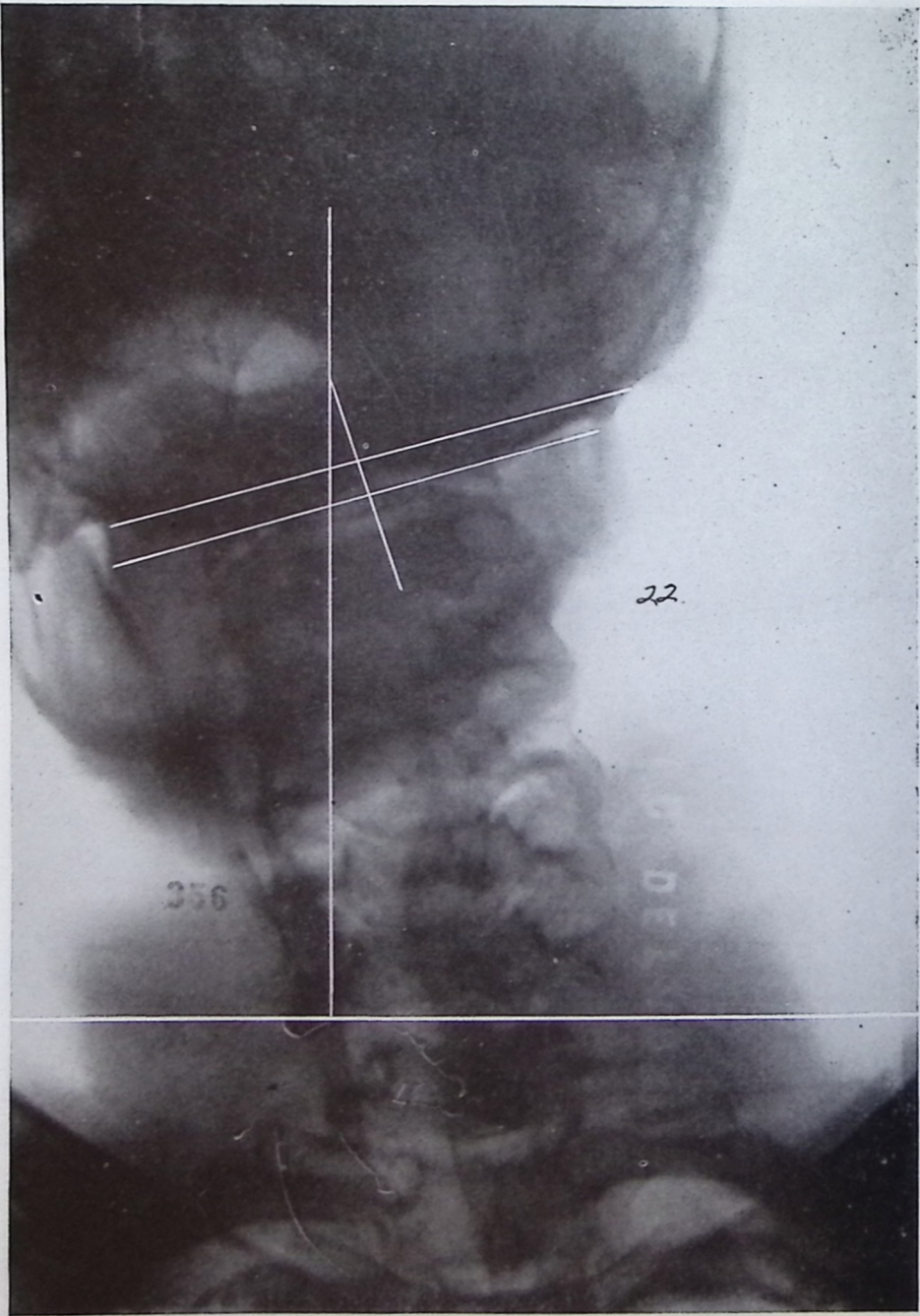


Illustration No. 356

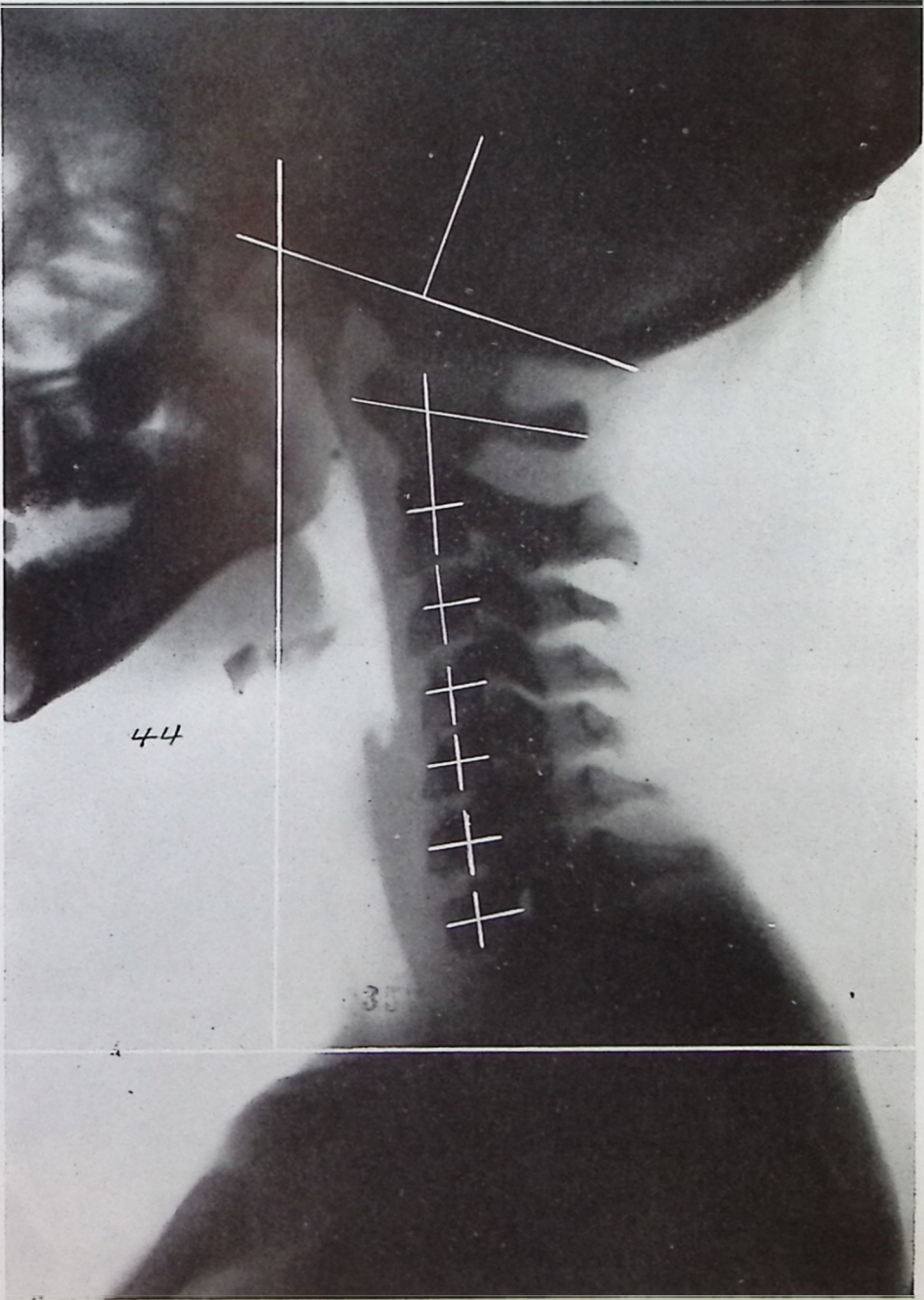


Illustration No. 357



Illustration No. 358

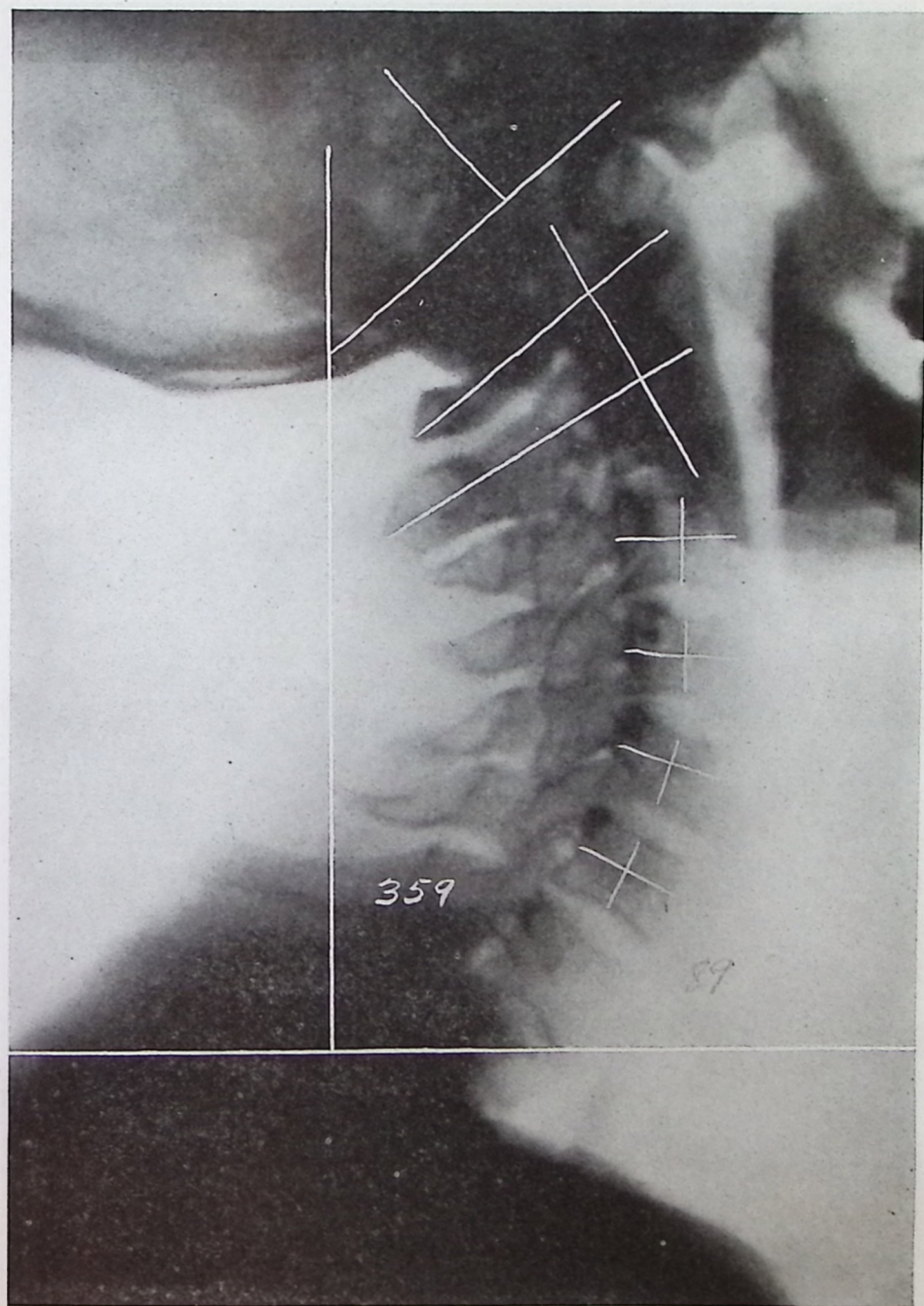


Illustration No. 359

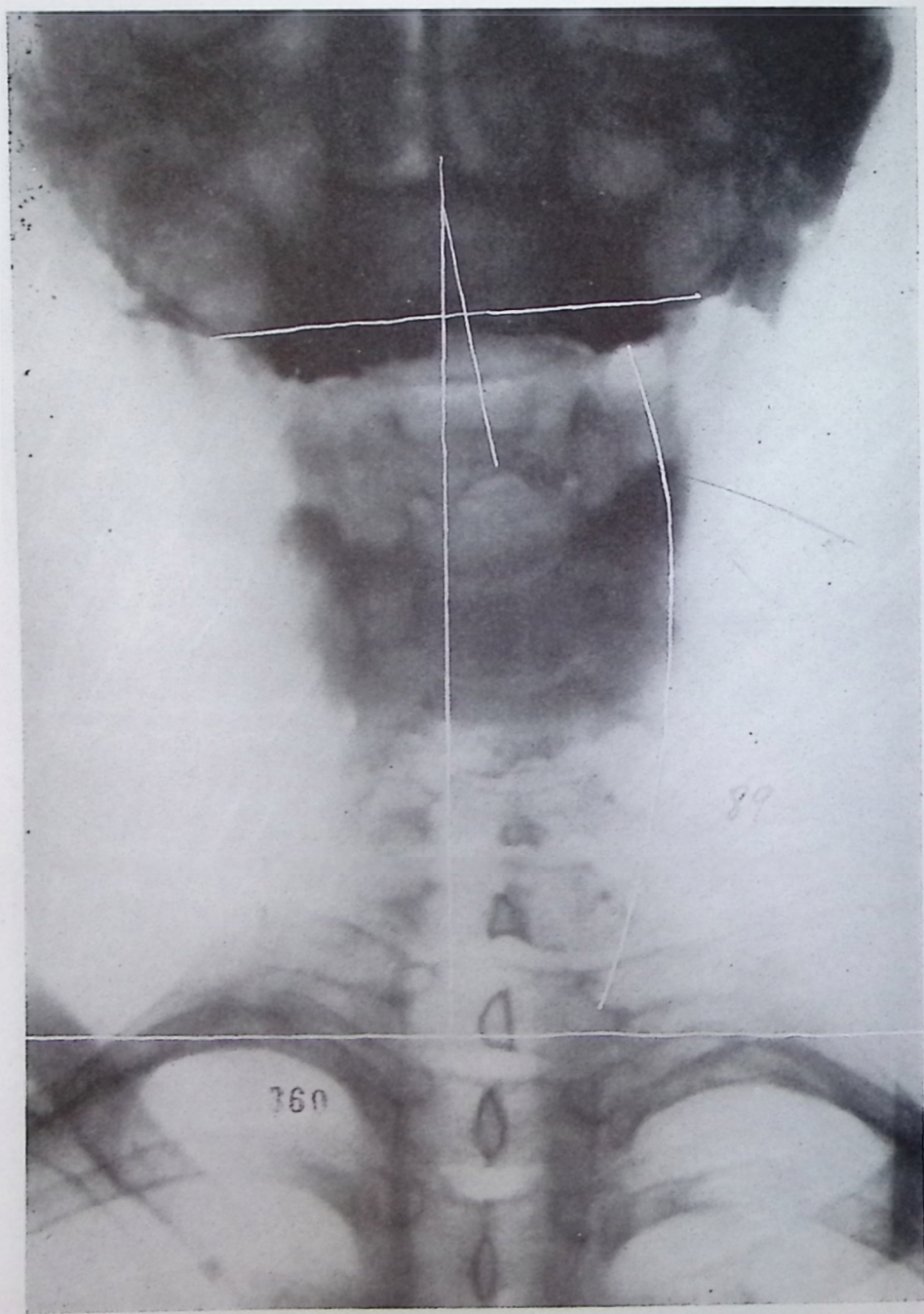


Illustration No. 360

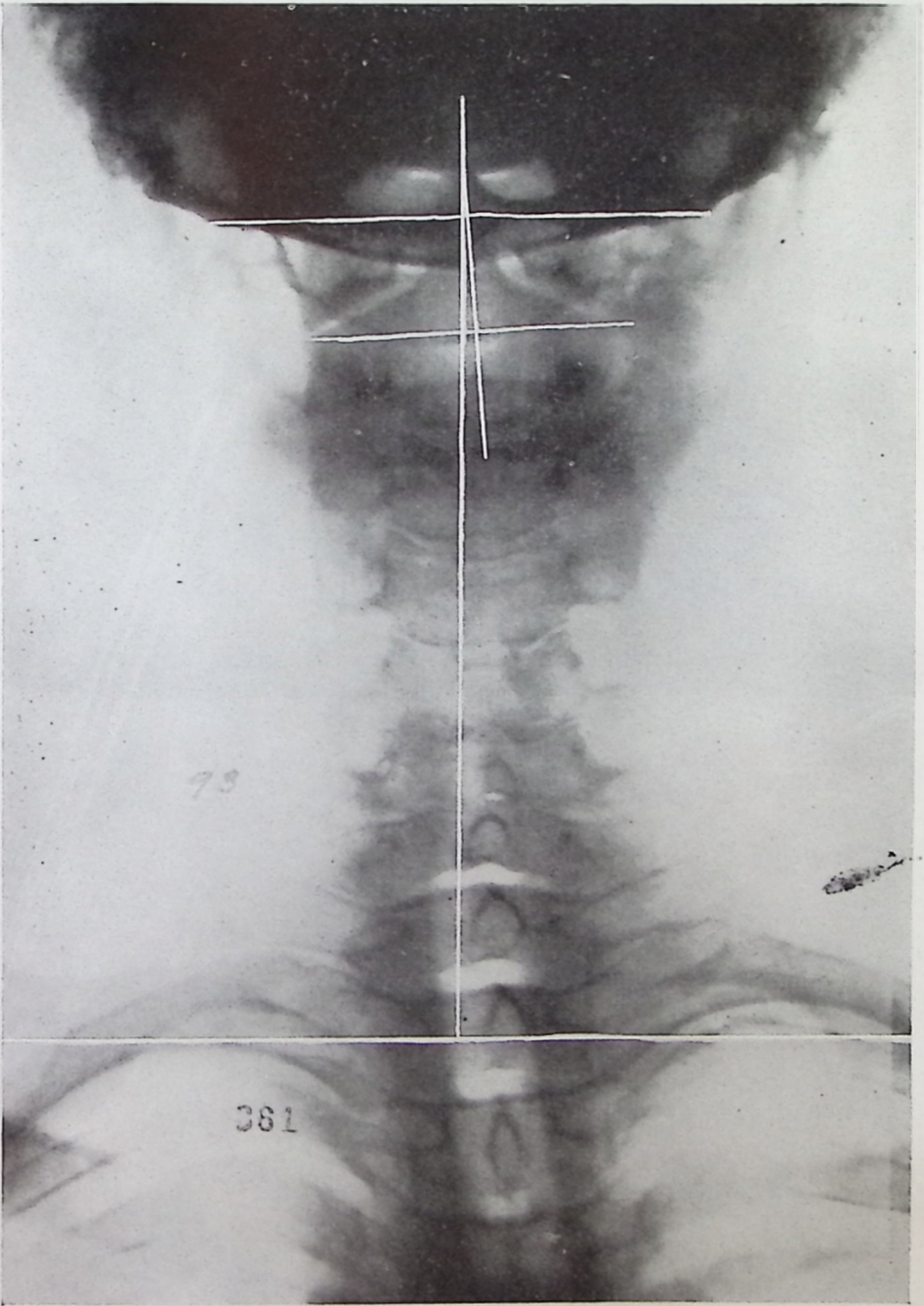


Illustration No. 361

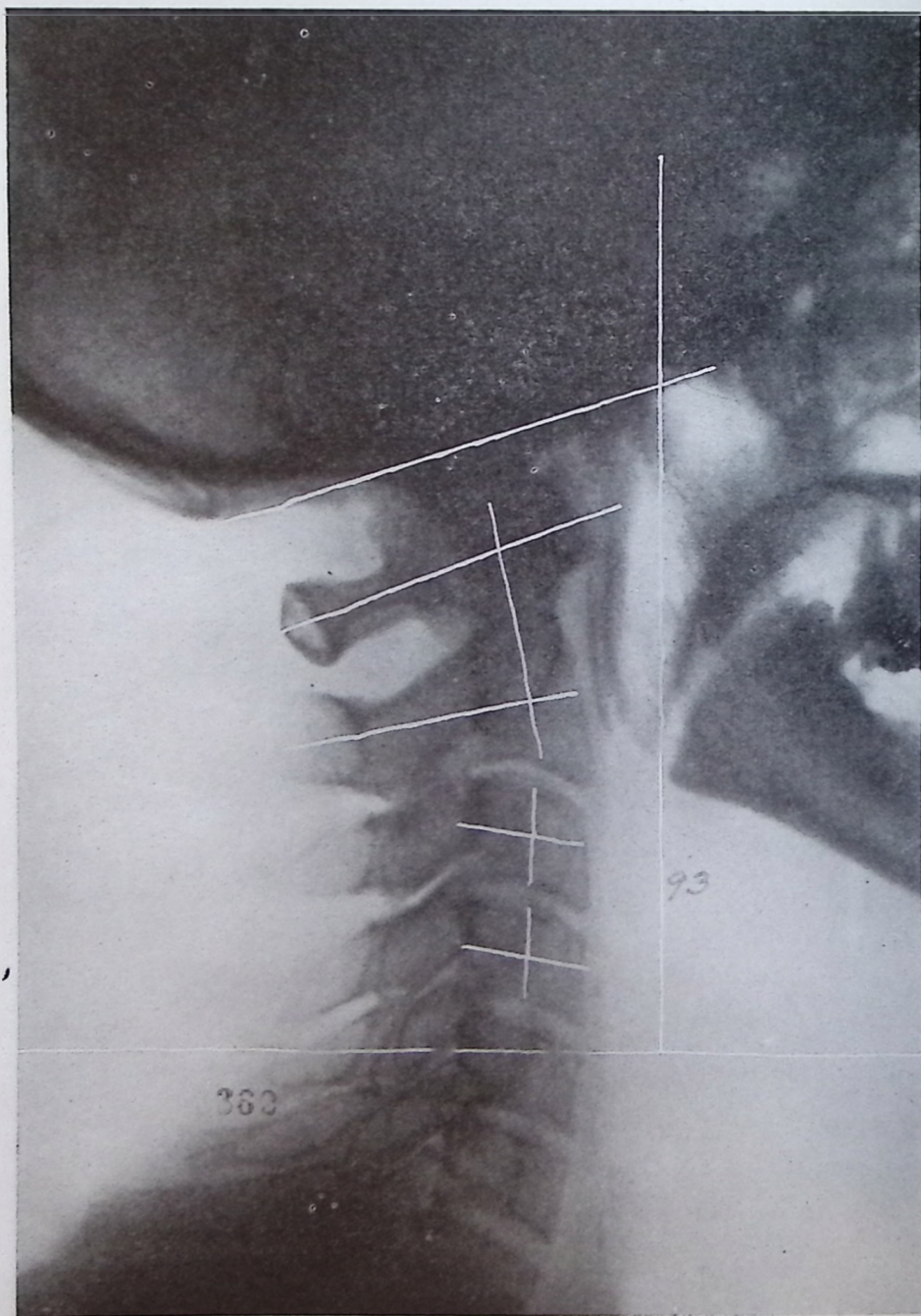


Illustration No. 362



Illustration No. 363

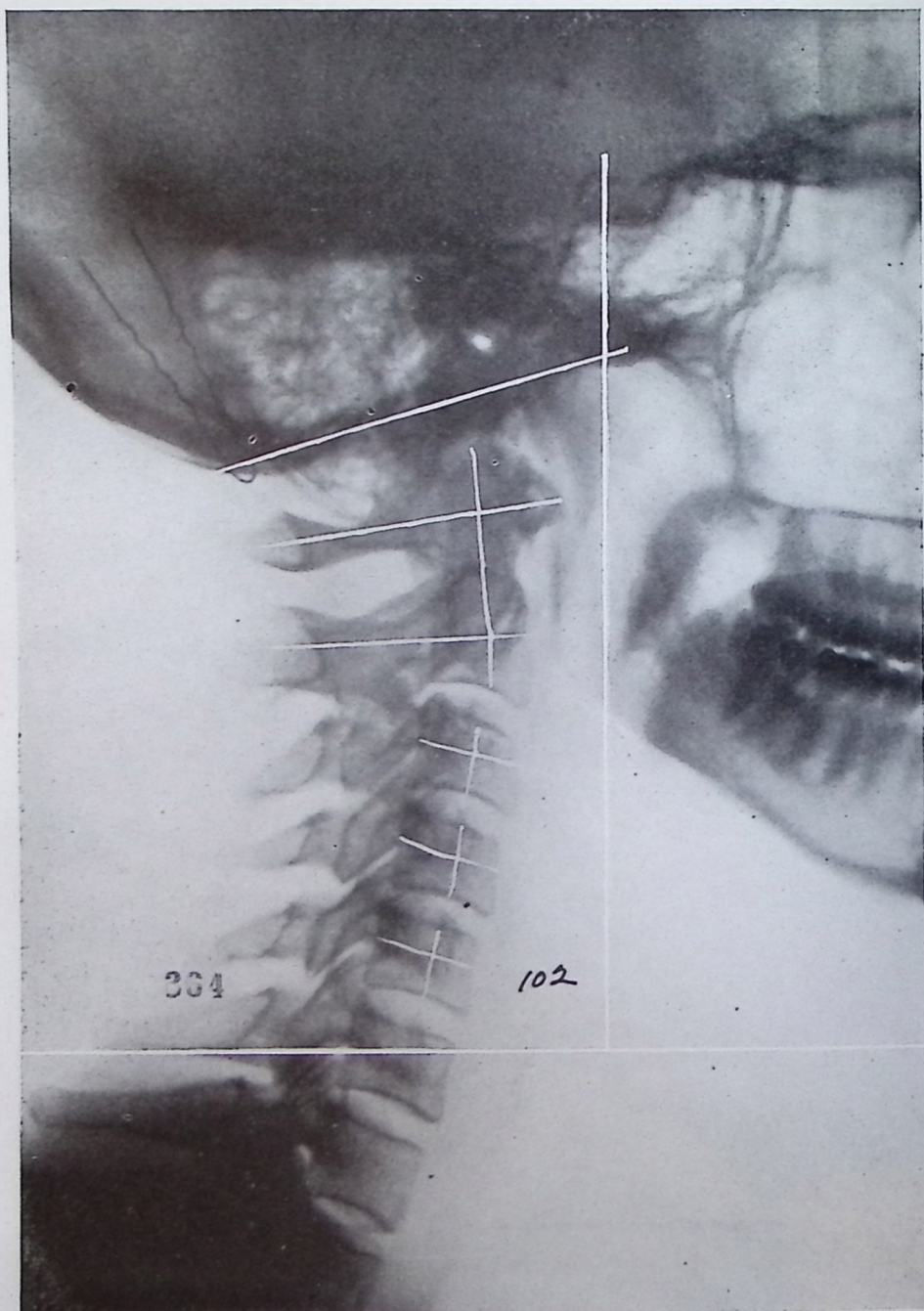


Illustration No. 364

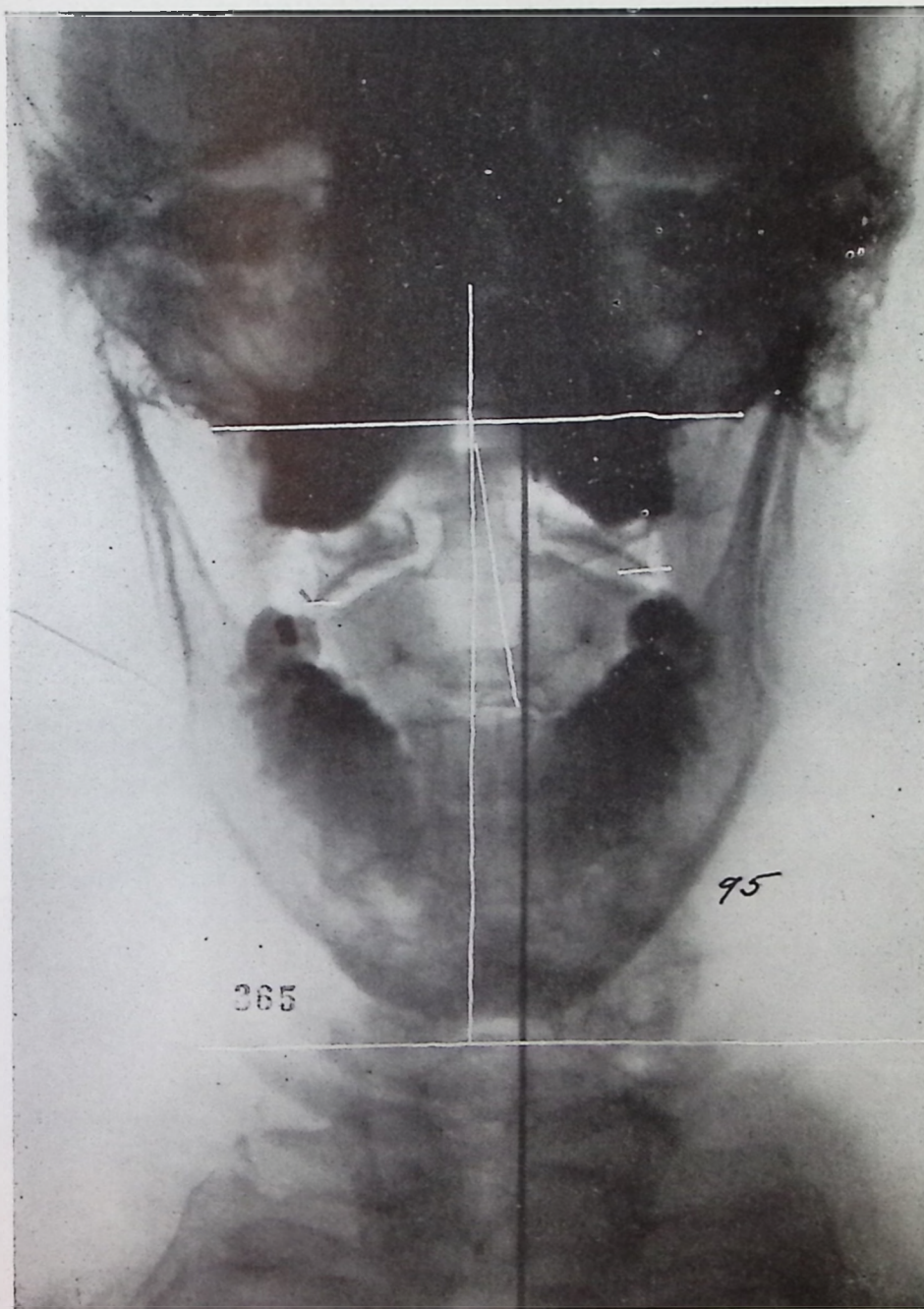


Illustration No. 365

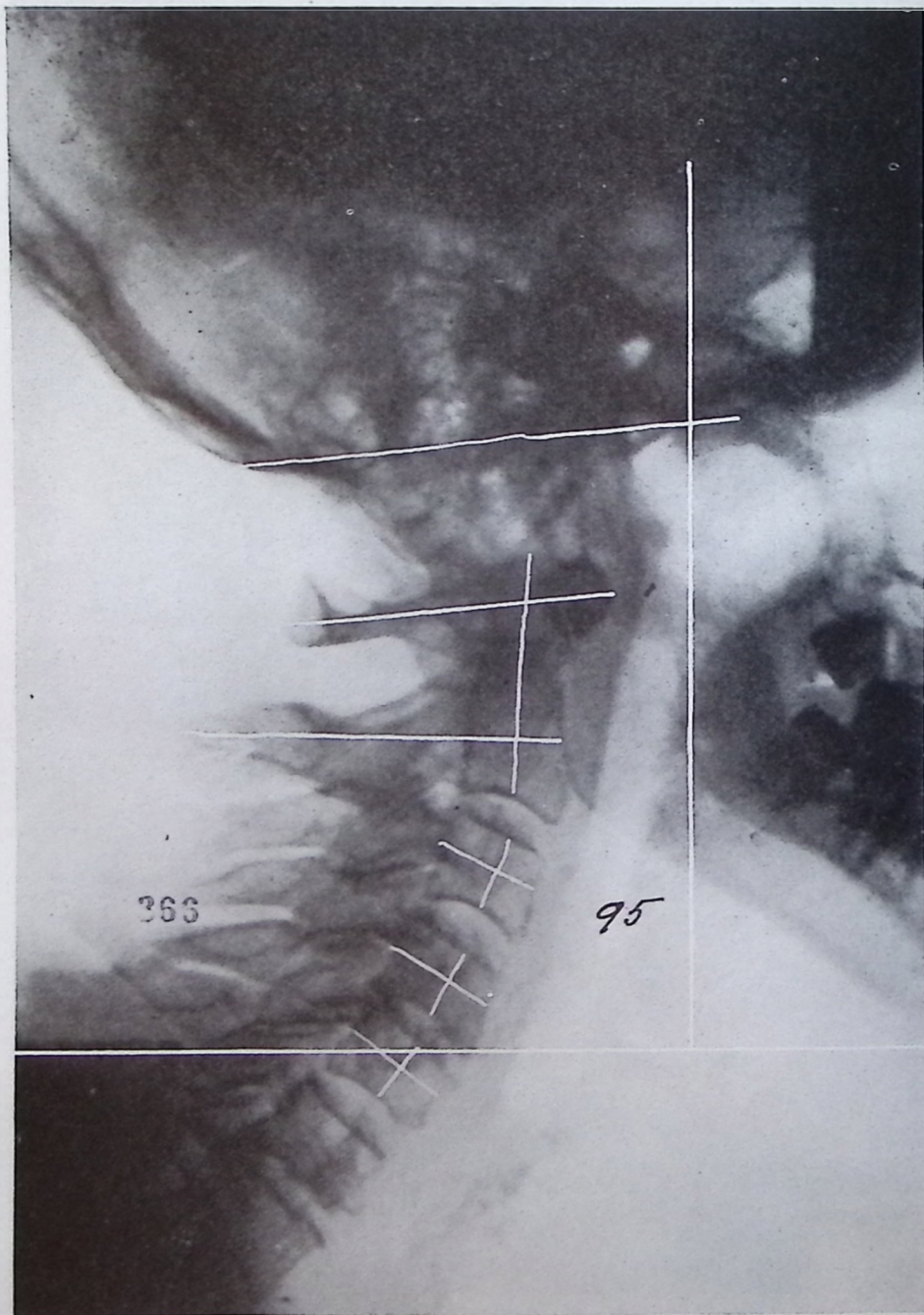


Illustration No. 366

CHAPTER XXXIV.
ATLAS ASL SUBLUXATION PLANE LINES.
Illustrations No. 367 to No. 376

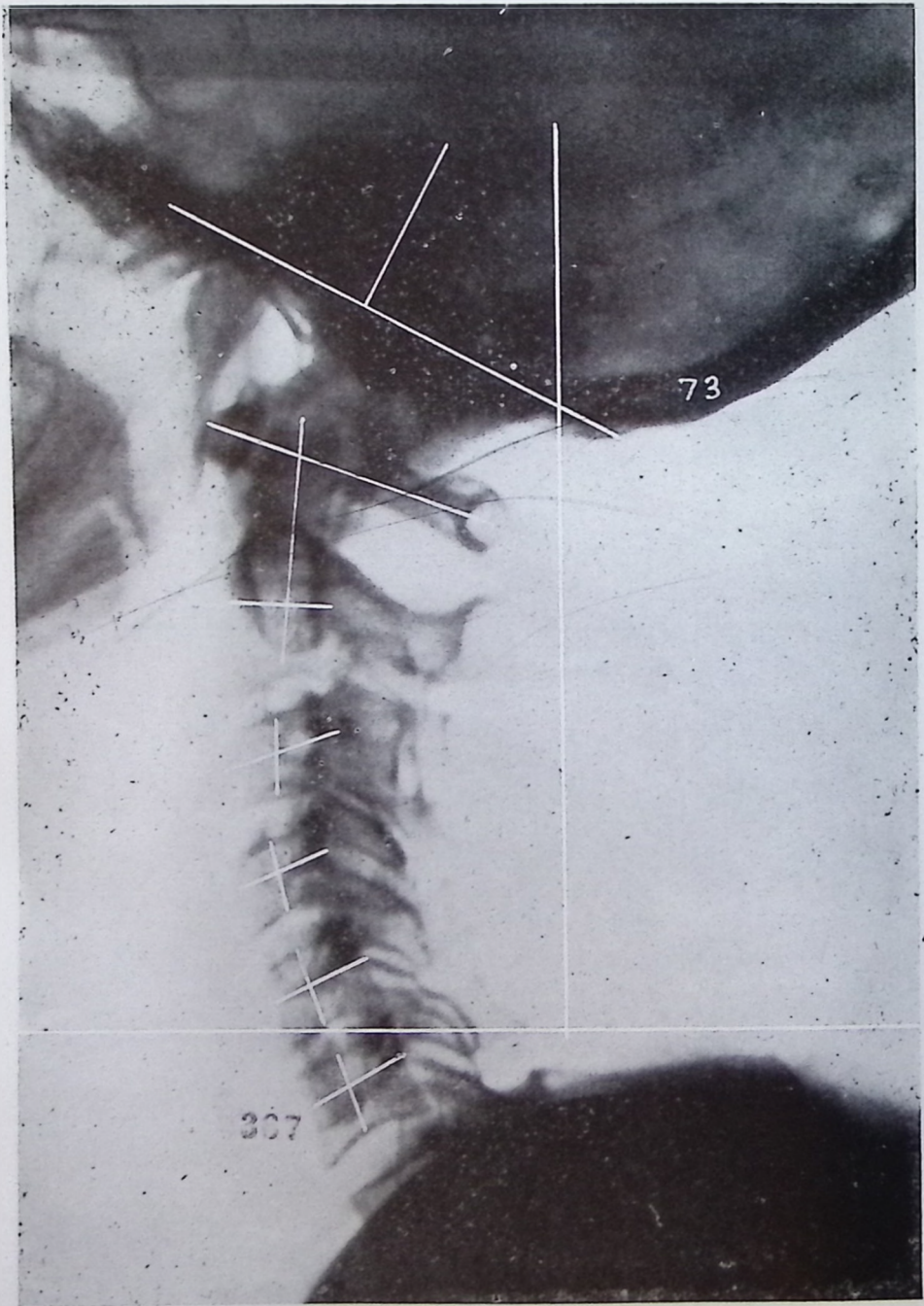


Illustration No. 367

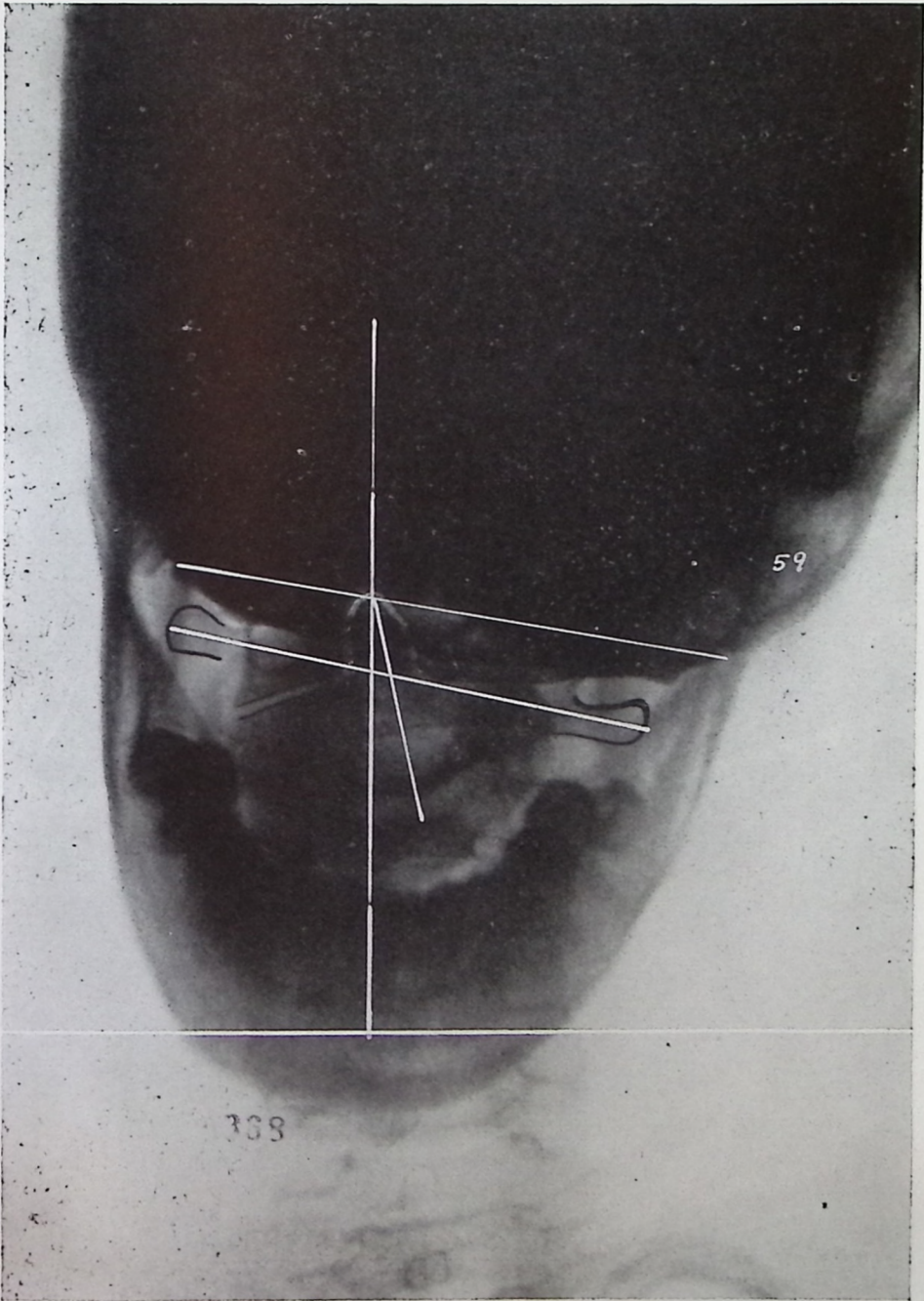


Illustration No. 368

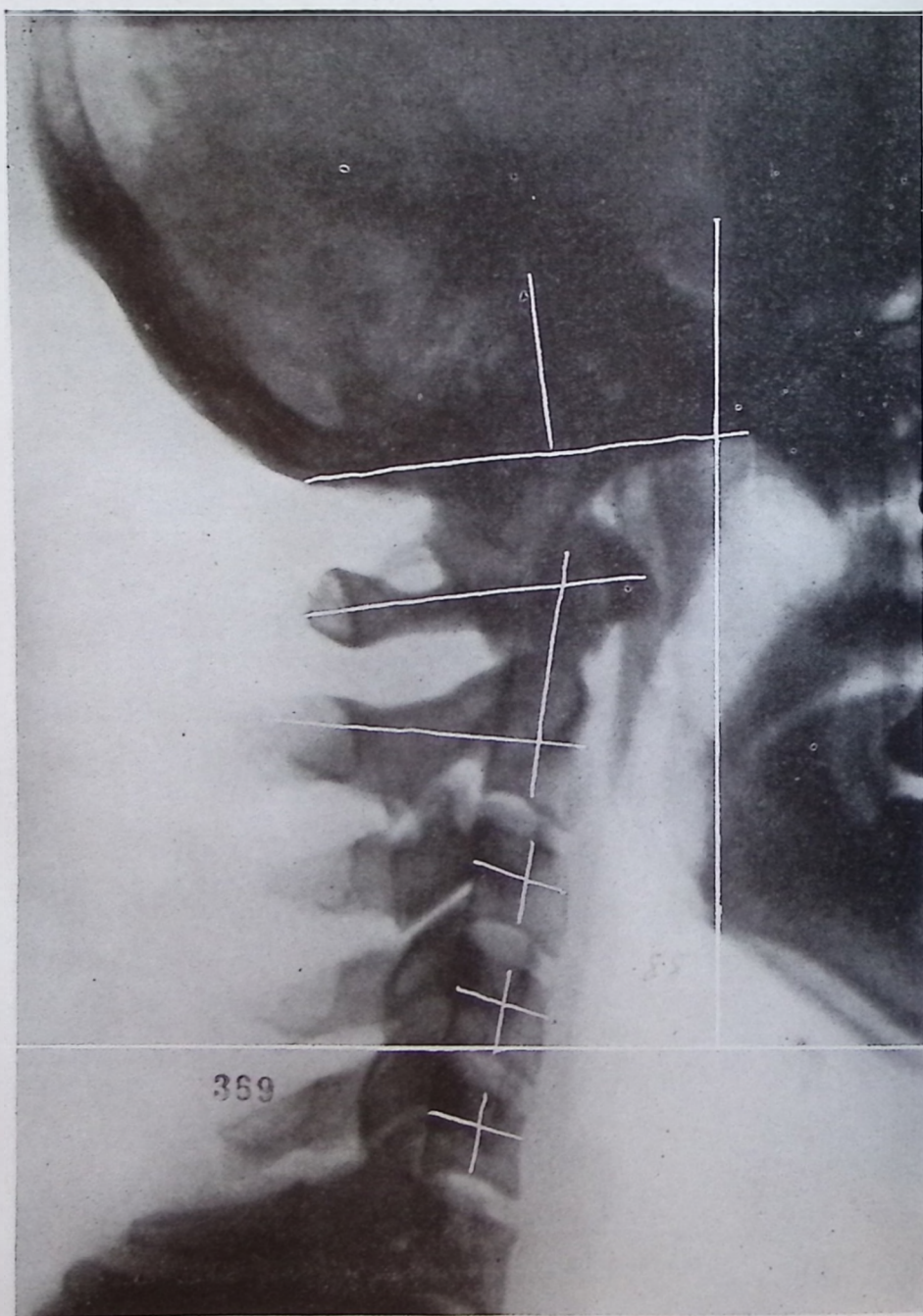


Illustration No. 369

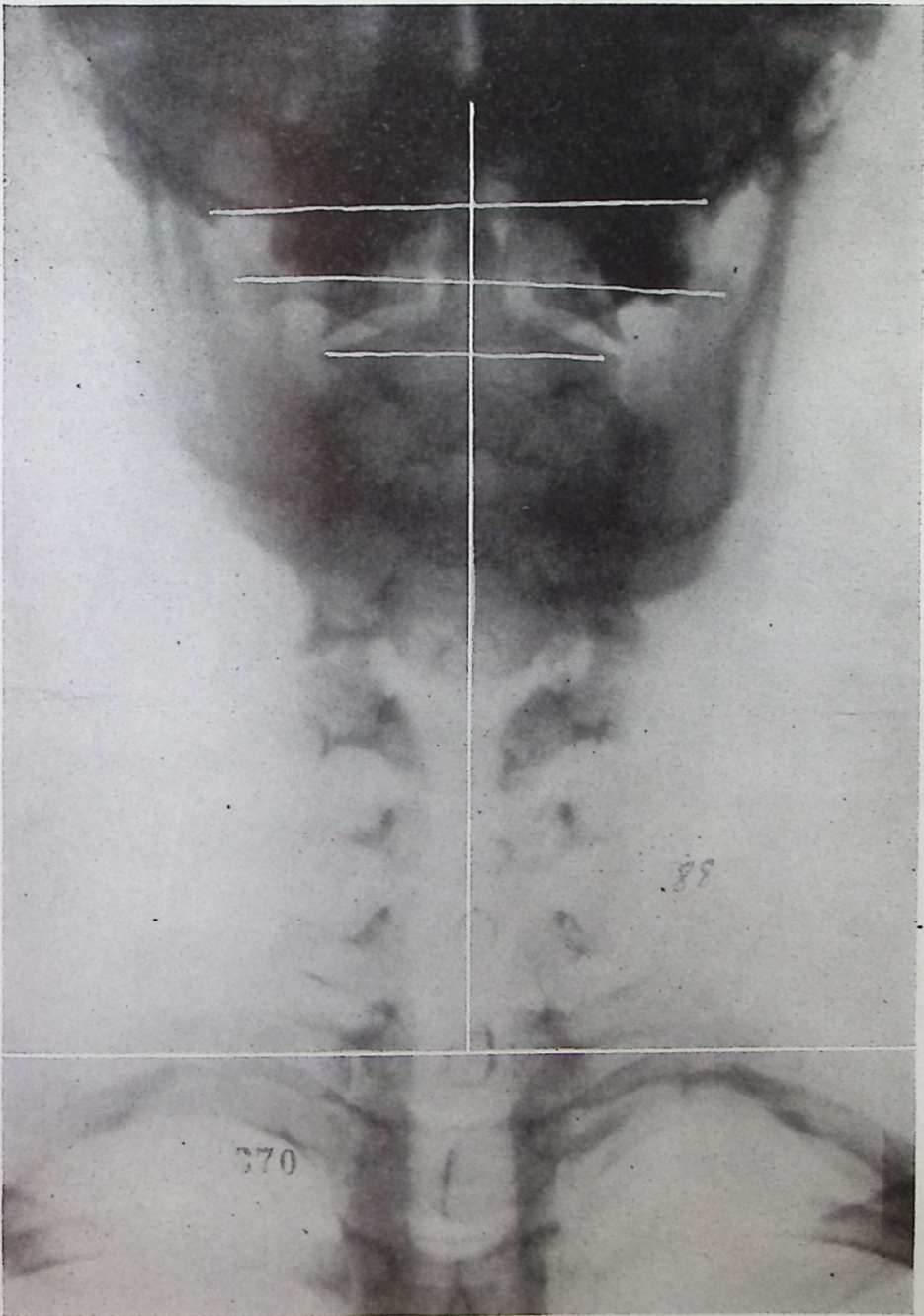


Illustration No. 370

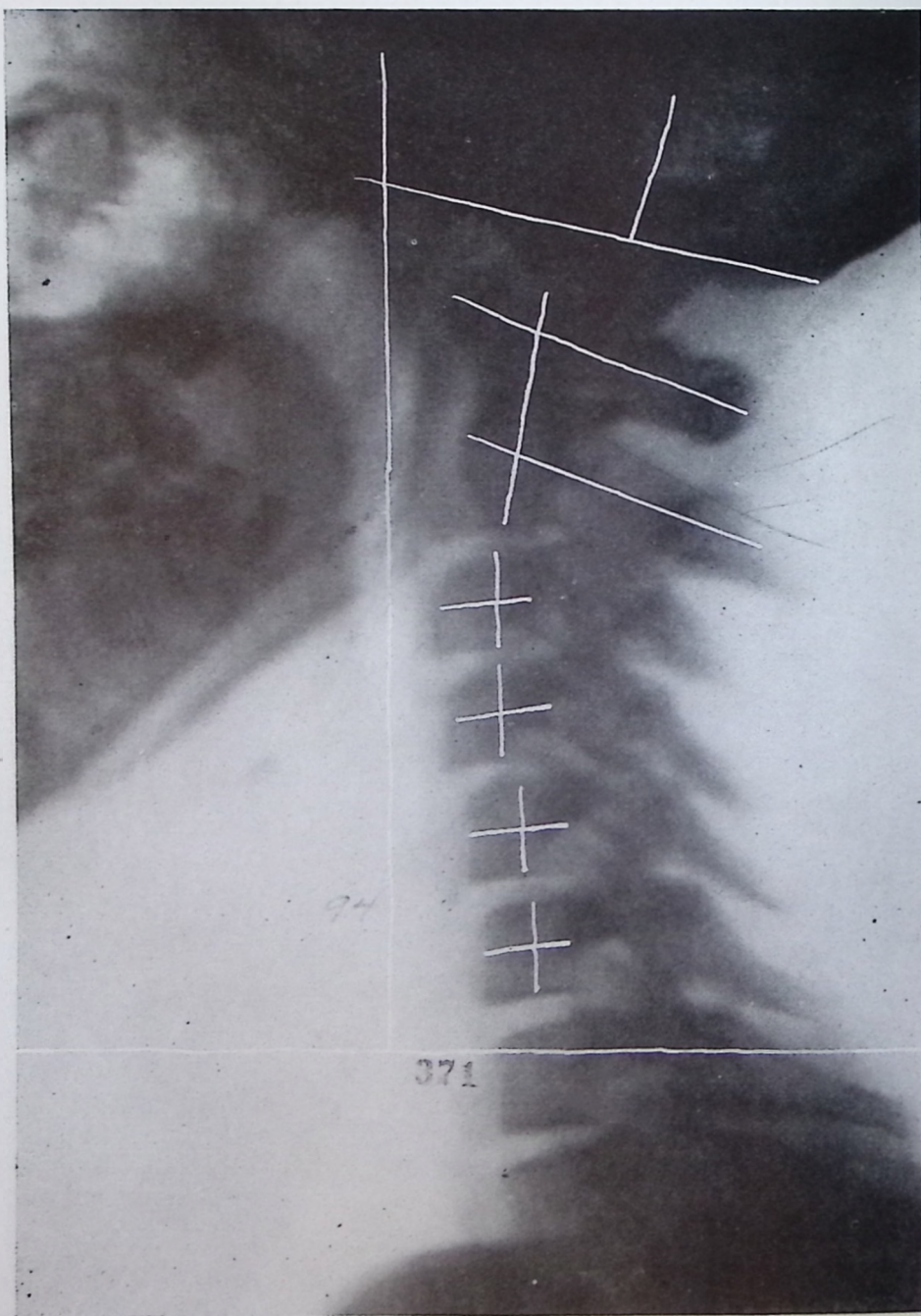


Illustration No. 371

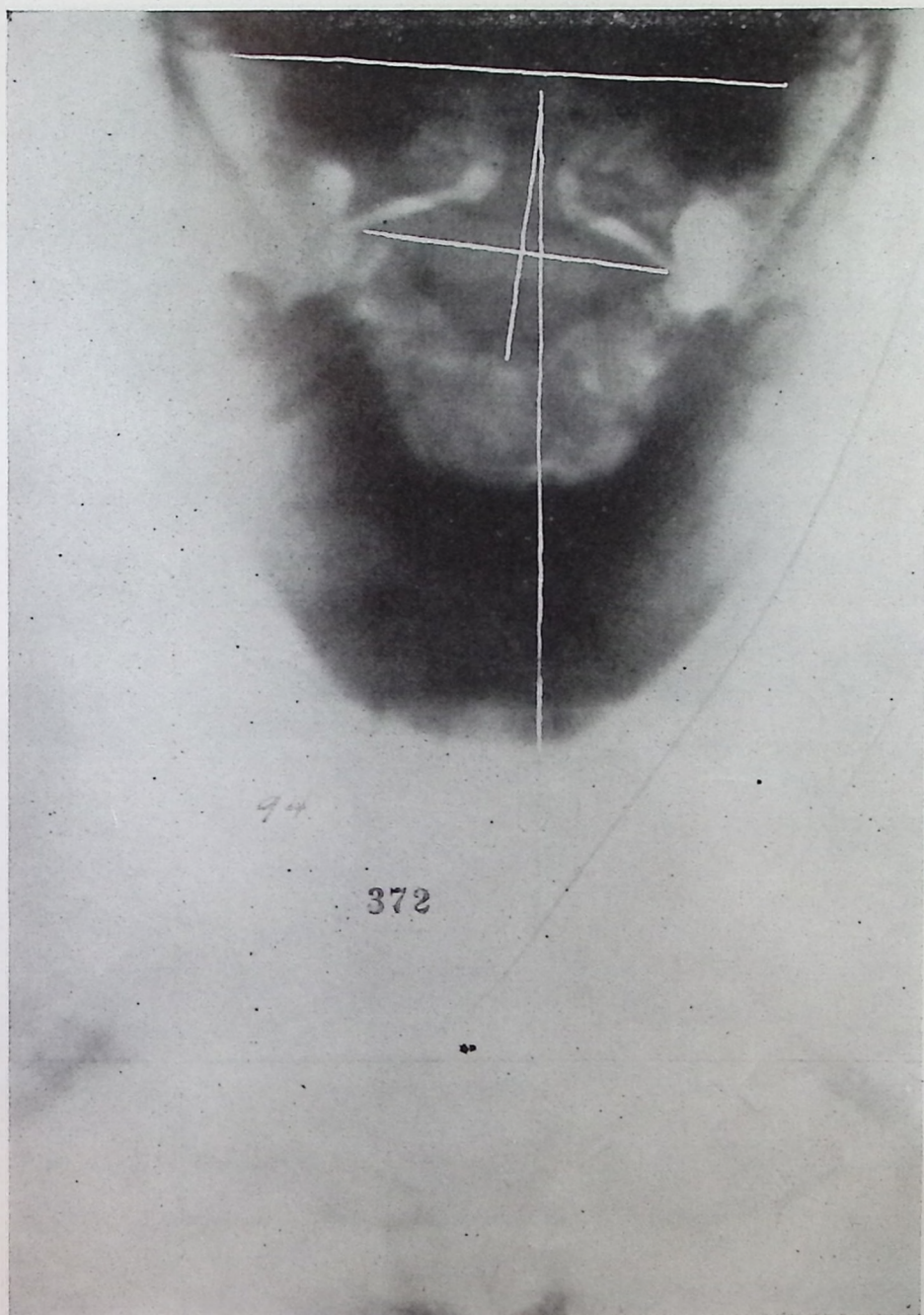


Illustration No. 372

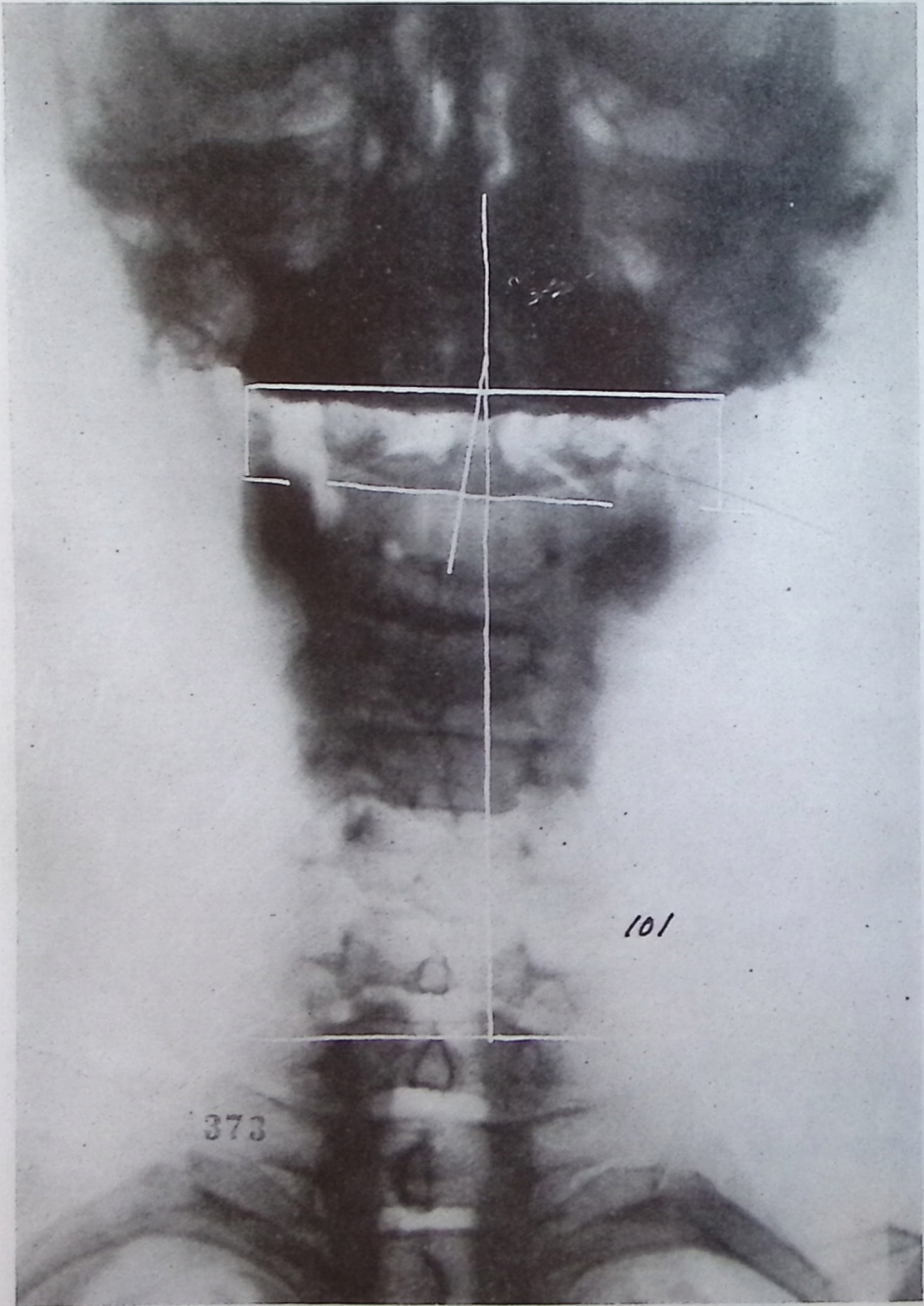


Illustration No. 373

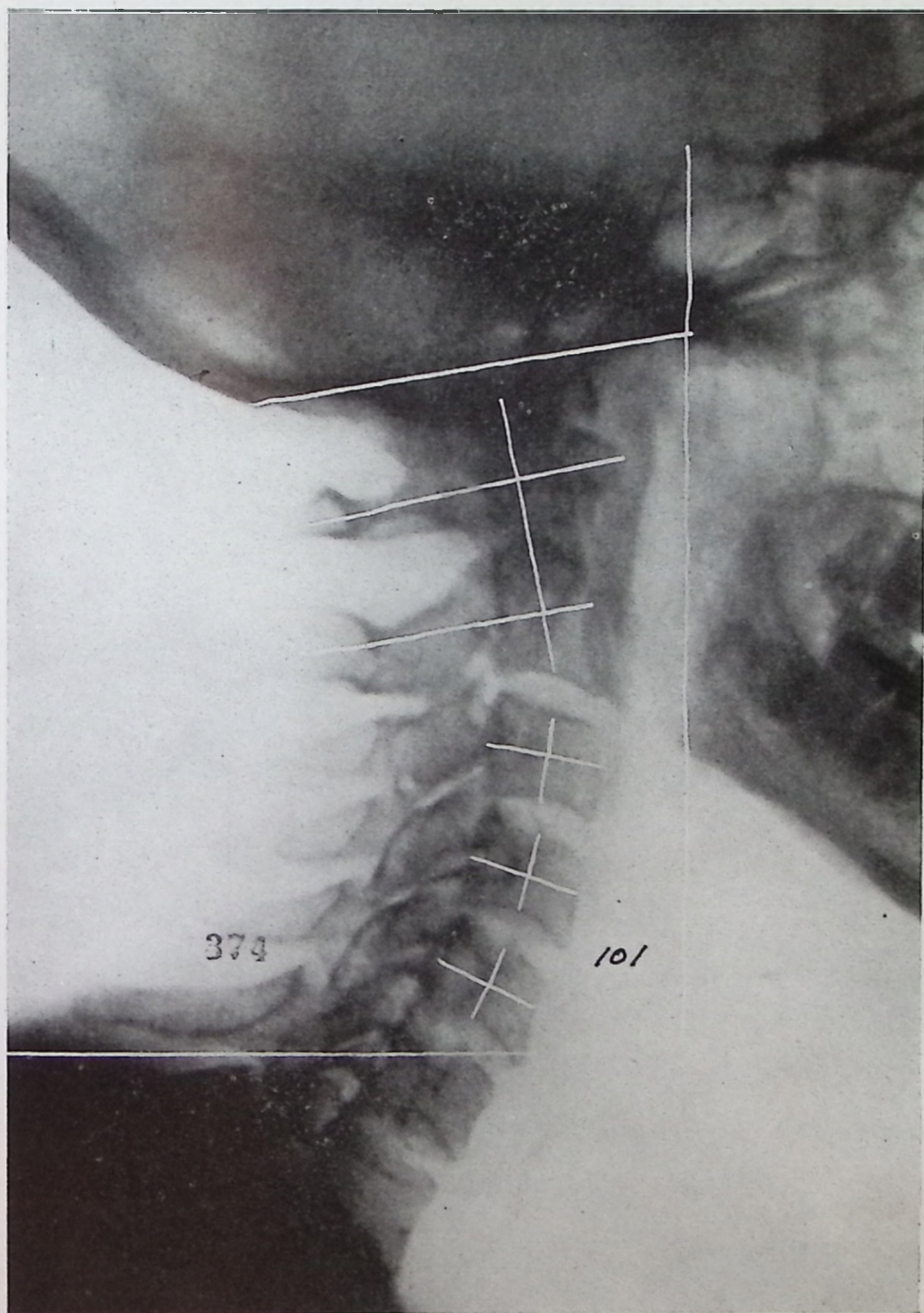


Illustration No. 374

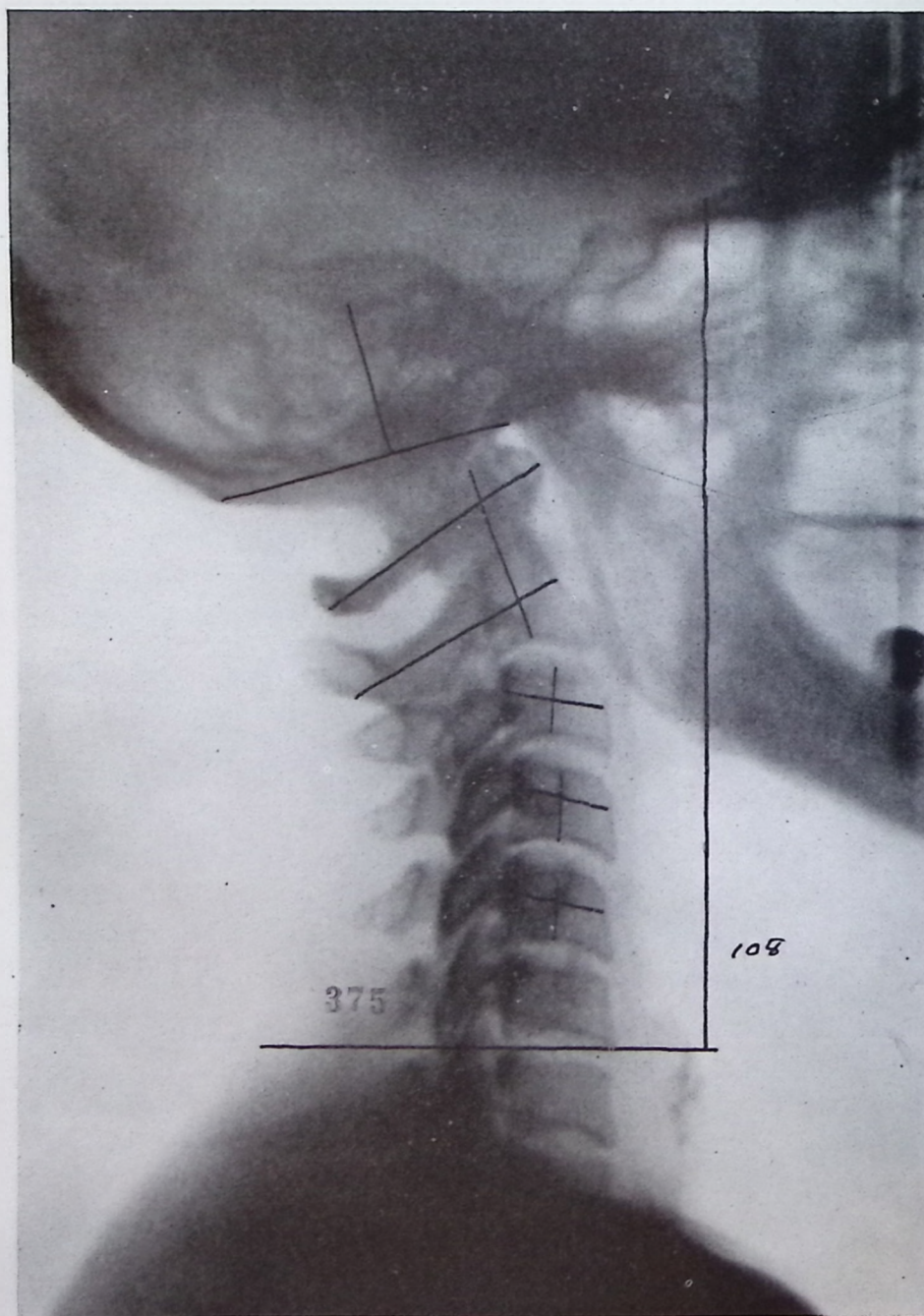


Illustration No. 375

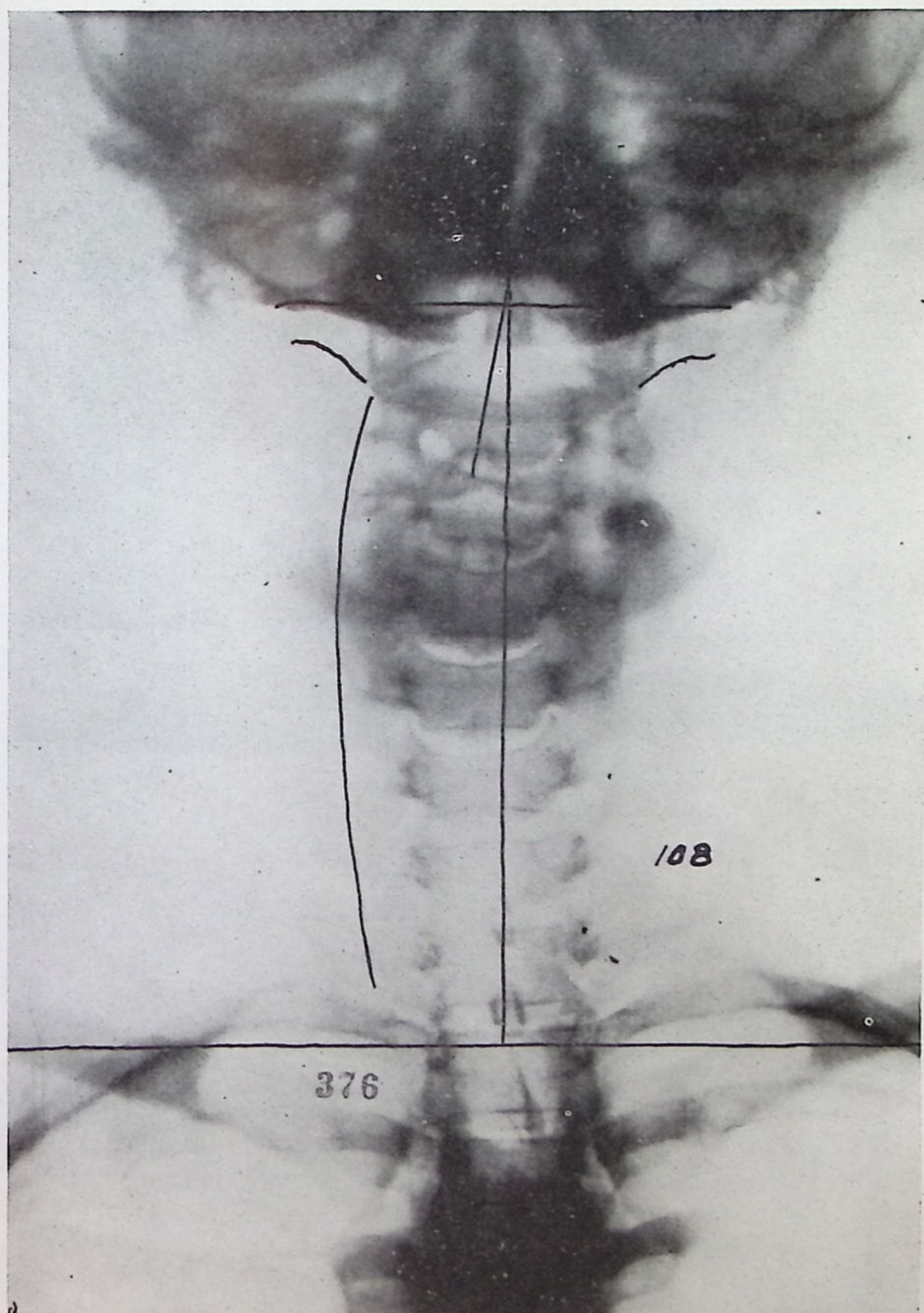


Illustration No. 376

CHAPTER XXXV.

ATLAS AIR SUBLUXATION PLANE LINES.

Illustrations No. 377 to No. 380

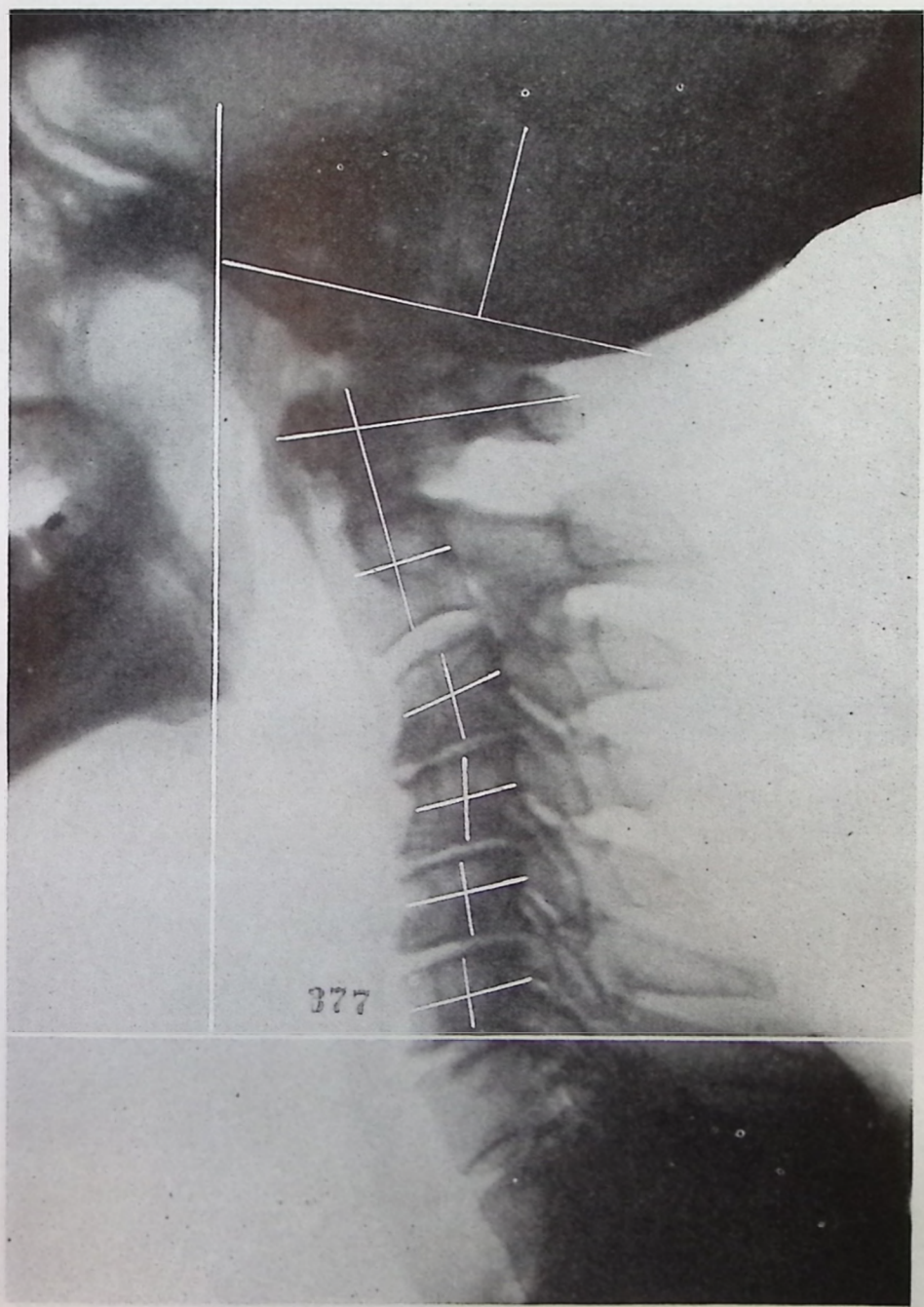


Illustration No. 377

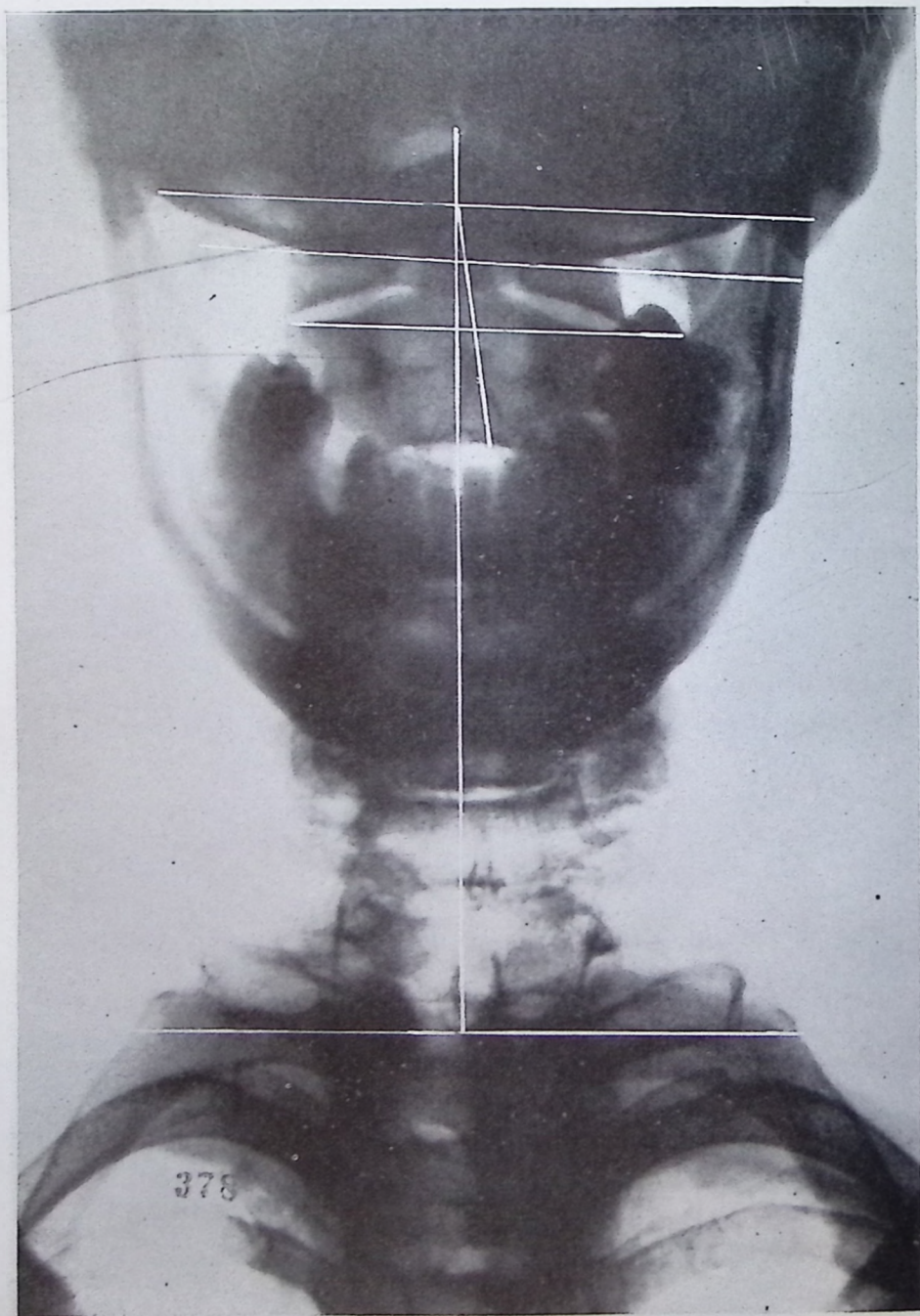


Illustration No. 378

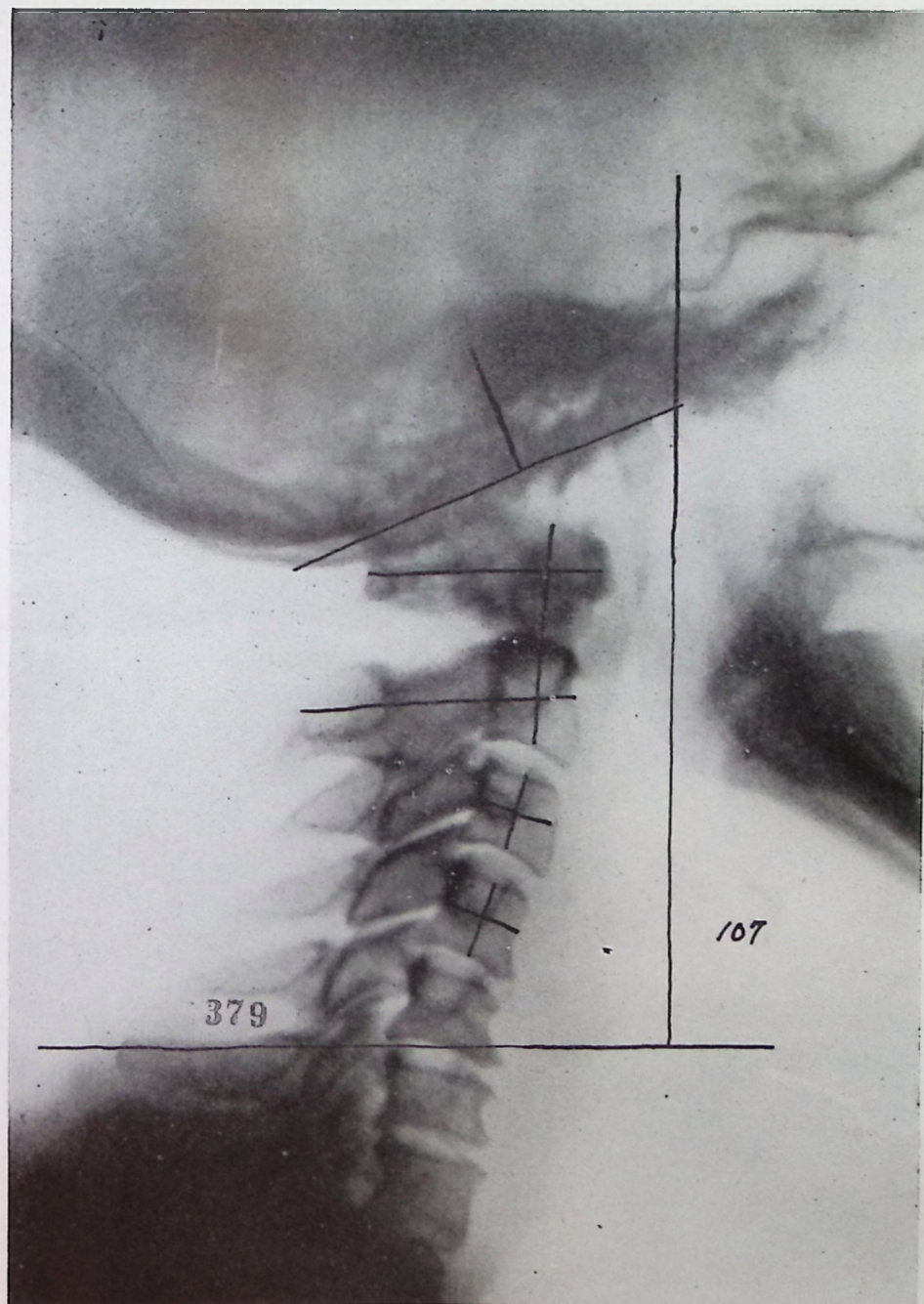


Illustration No. 379

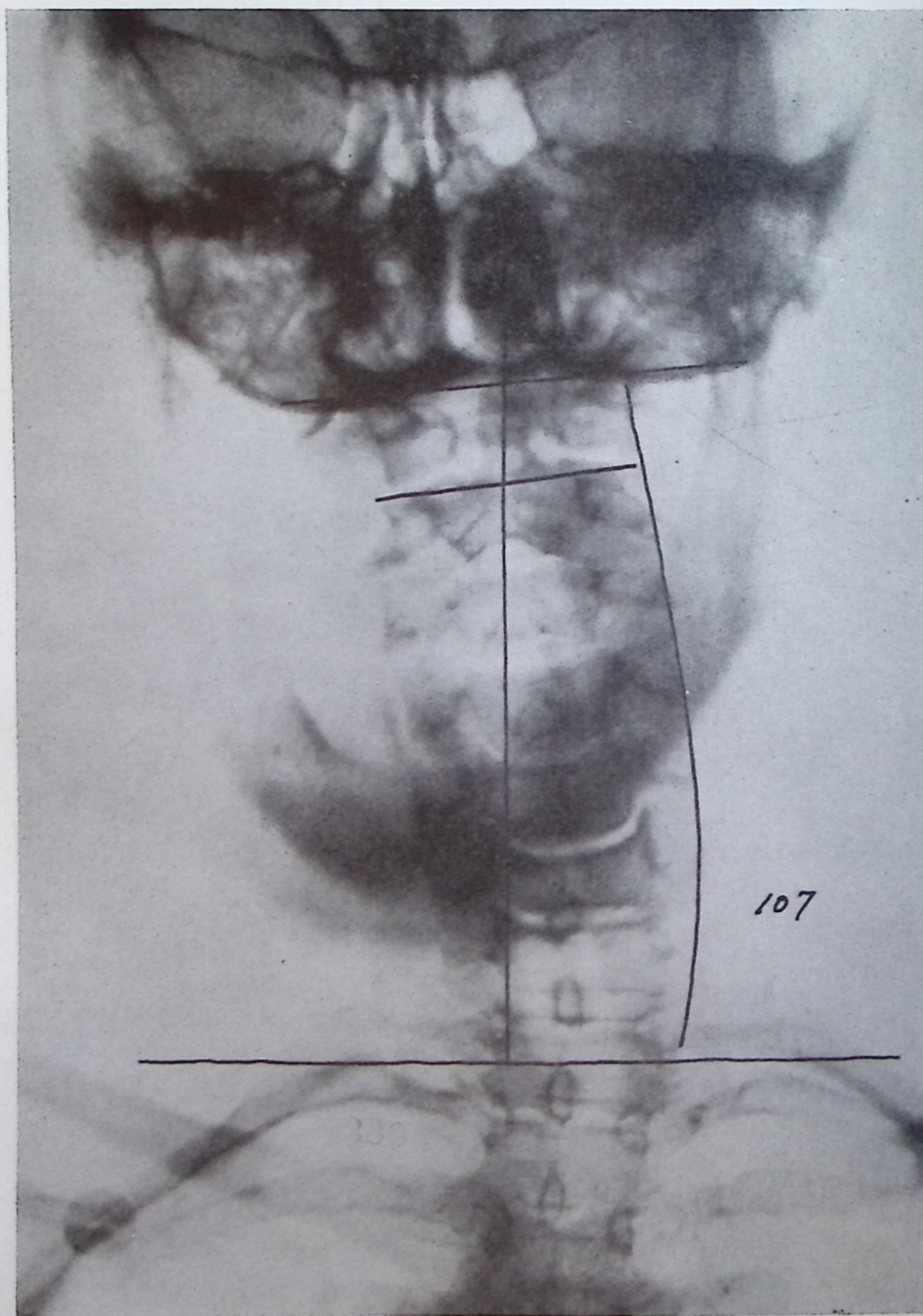


Illustration No. 380

CHAPTER XXXVI.

ATLAS AIL SUBLUXATION PLANE LINES.

Illustrations No. 381 to No. 382



Illustration No. 381

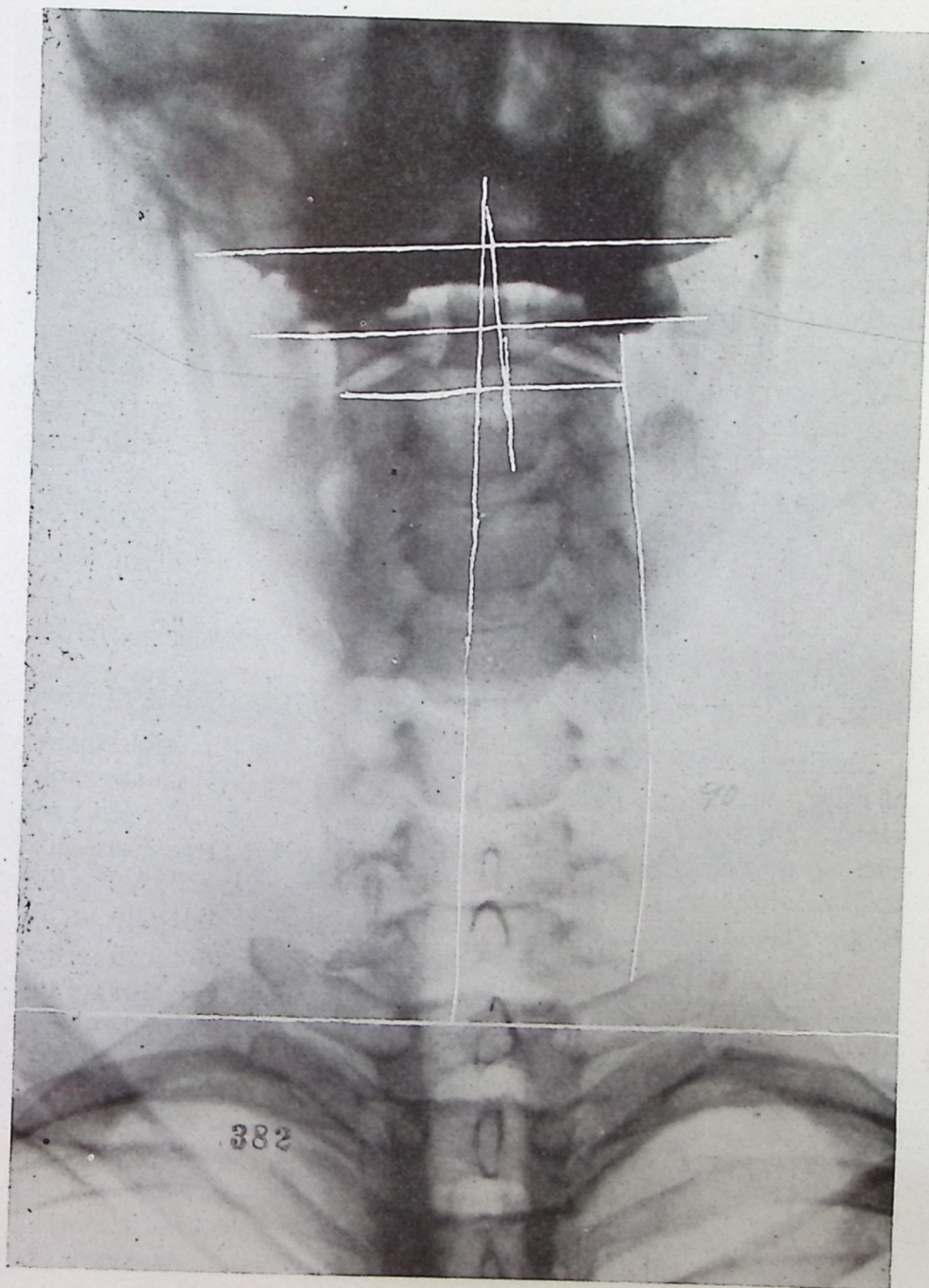


Illustration No. 382

CHAPTER XXXVII

R. HI WEDGE-SIDE-SLIP ATLAS SUBLUXATIONS

Illustrations 383 to 403 are R. HI wedge-side-slip sublaxations of atlas. In this group we have portrayed only A-P spinographic views. Lateral views would follow previous rules. For that reason we do not here give complete listing. R. HI as here illustrated might be ASR or AIR. We have portrayed A-P views to give plane lines and to show degree of wedge-shape on R.

We commend your attention to varying degree of differences as to degree of "HI" as well as degree of wedge-side-slip sublaxation of atlas as suggested by difference in thinness or thickness of wedge on R.

CHAPTER XXXVIII

R. LO WEDGE-SIDE-SLIP SUBLUXATIONS OF ATLAS

Illustrations 404 to 417 are R. LO wedge-side-slip sublaxations of atlas. In this group we have portrayed only A-P spinographic views. Lateral views would follow previous rules. For that reason we do not here give complete listing. R. LO as here illustrated might be ASR or AIR. We have portrayed A-P views to give plane lines and to show degree of wedge-side-slip on R.

— We commend your attention to varying degree of differences as to degree of "LO" as well as degree of wedge-side-slip sublaxation of atlas as suggested by difference in thinness or thickness of wedge on R.



Illustration No. 383

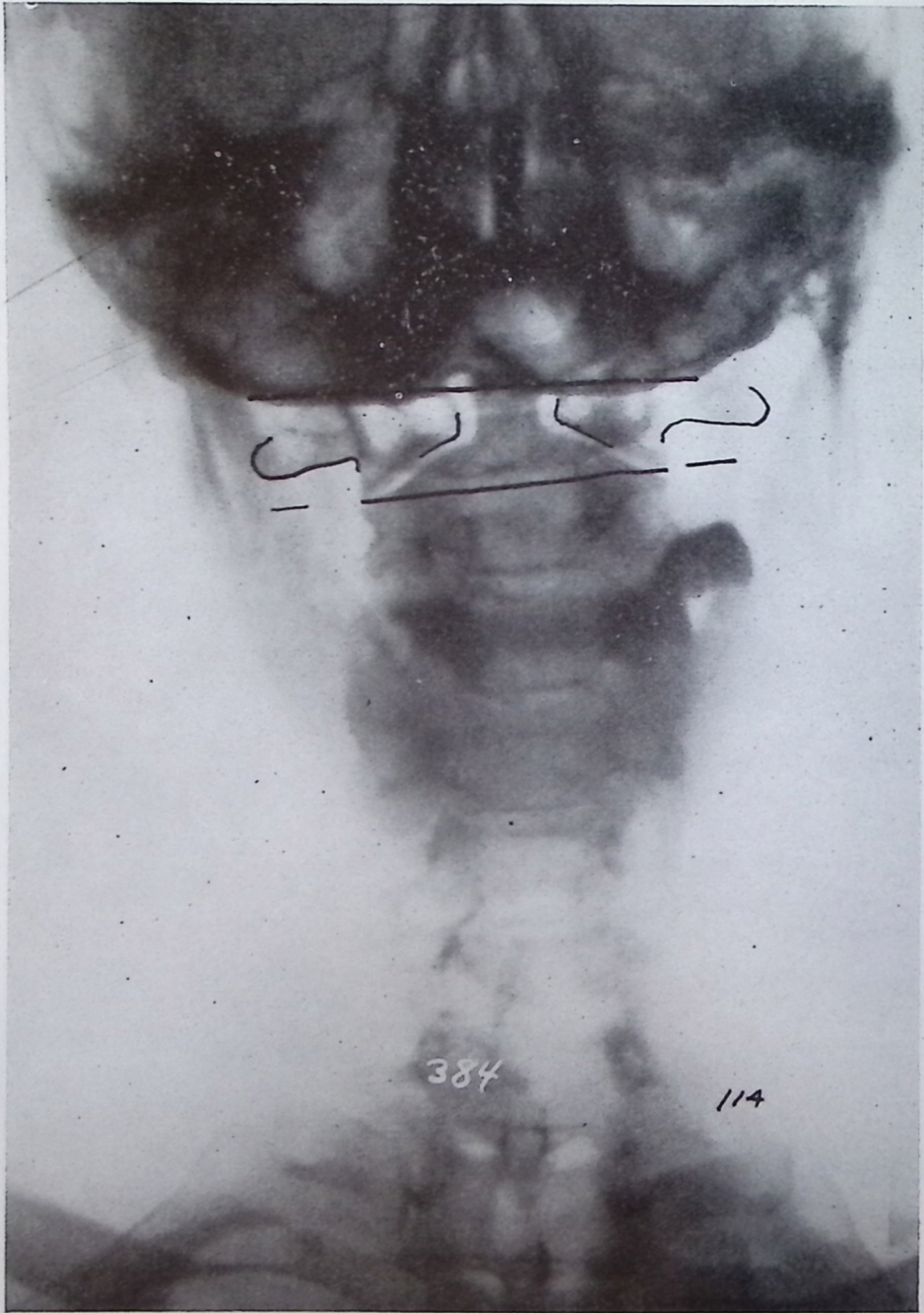


Illustration No. 384



Illustration No. 385

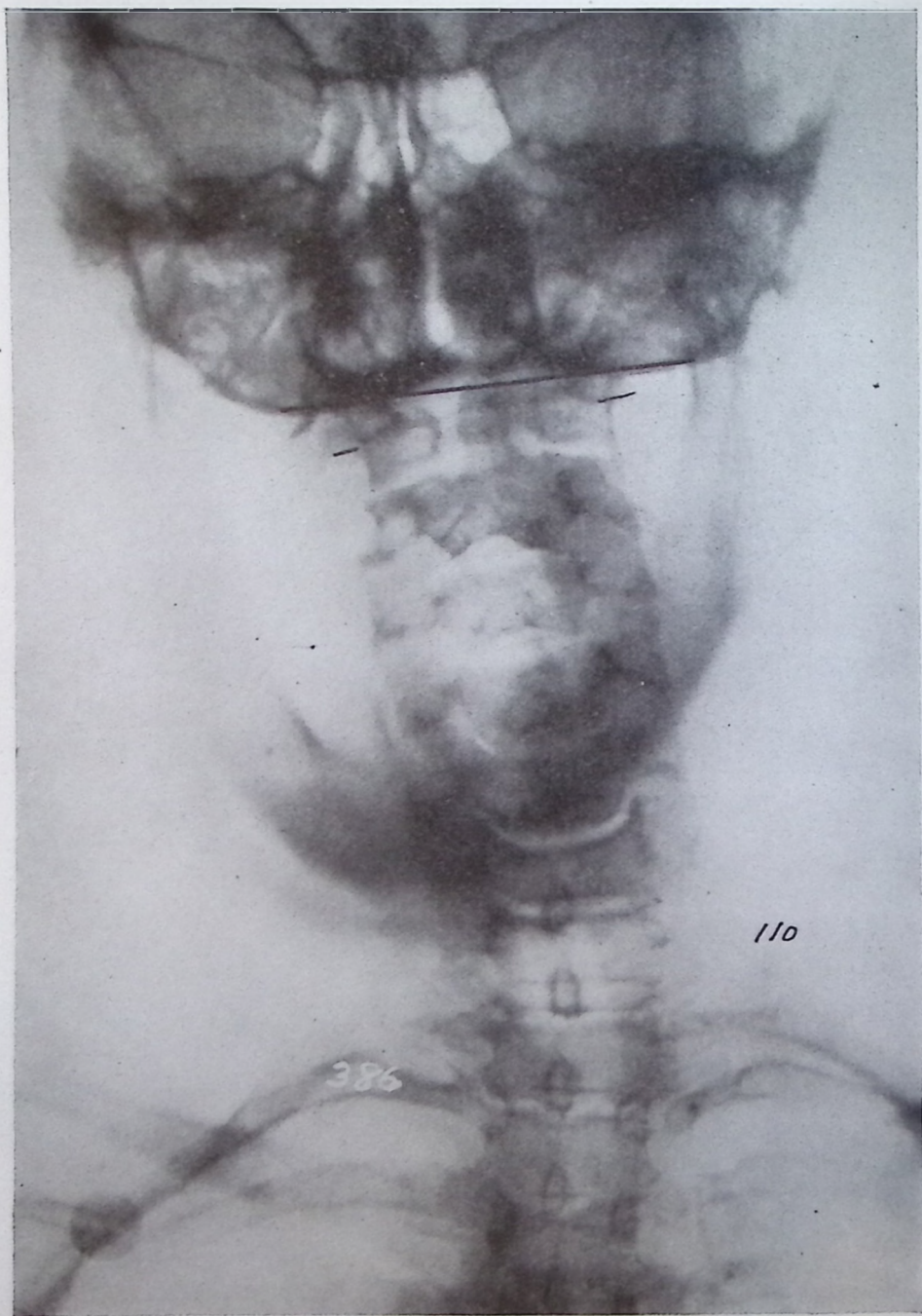


Illustration No. 386

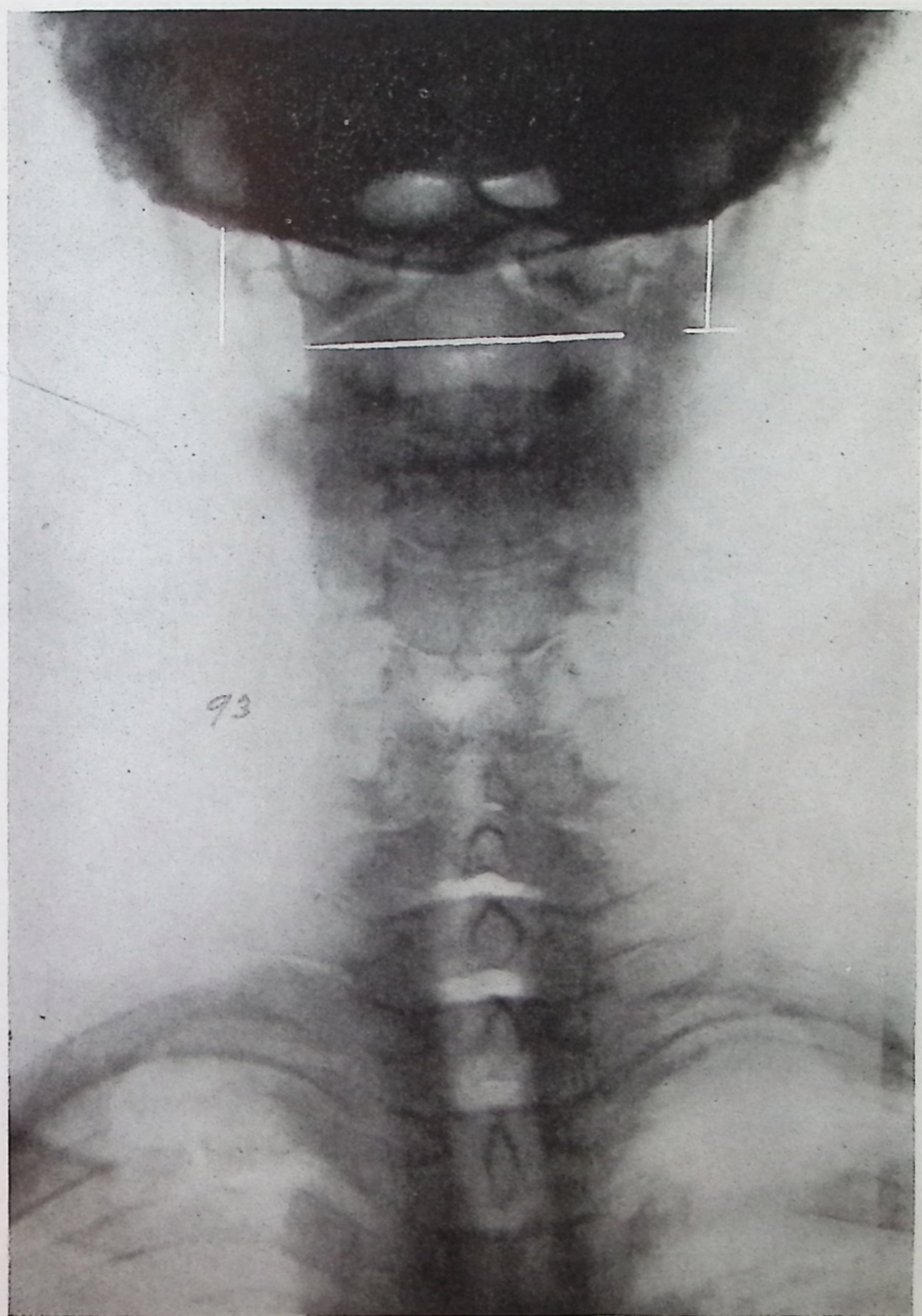


Illustration No. 387



Illustration No. 388

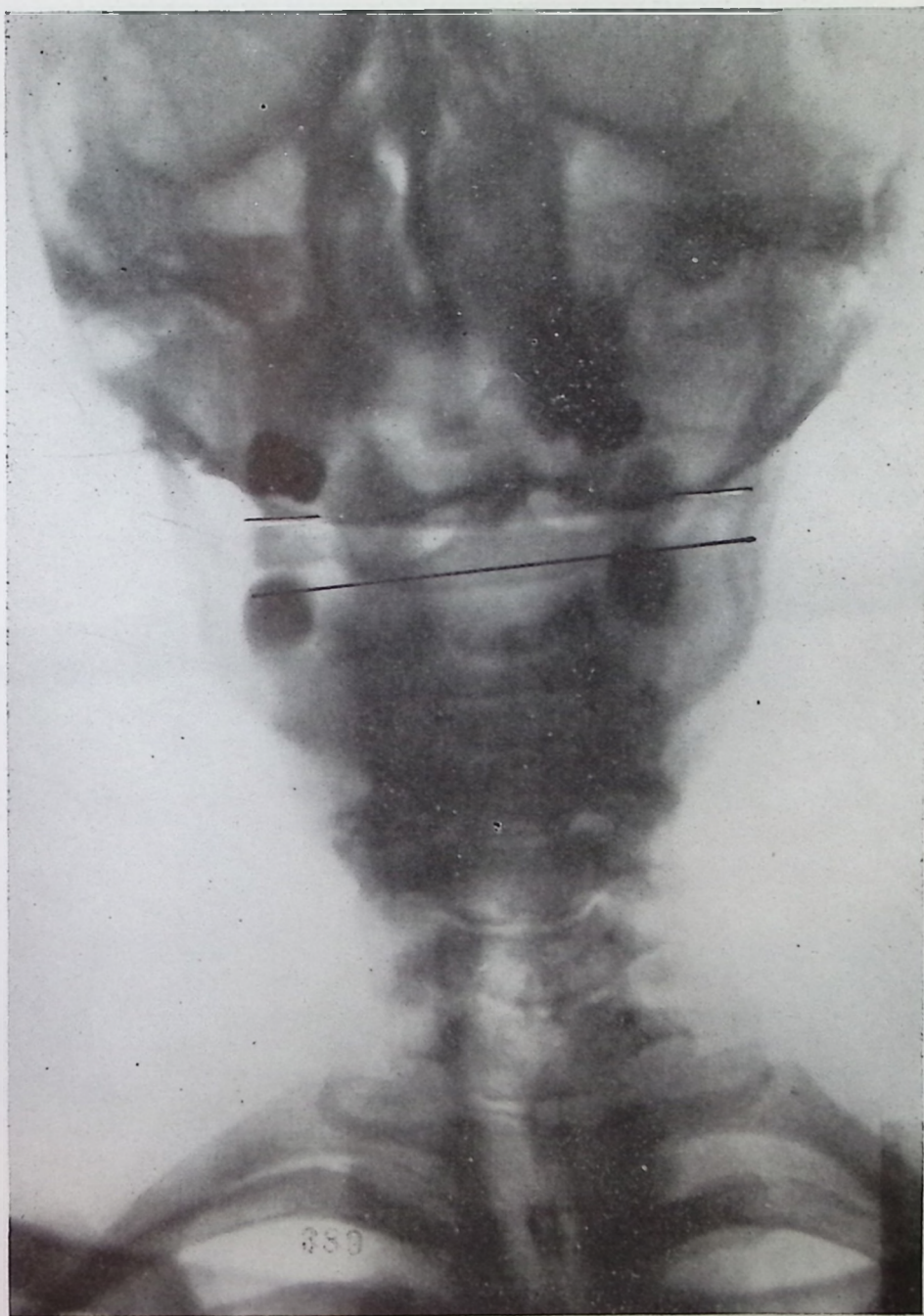


Illustration No. 389

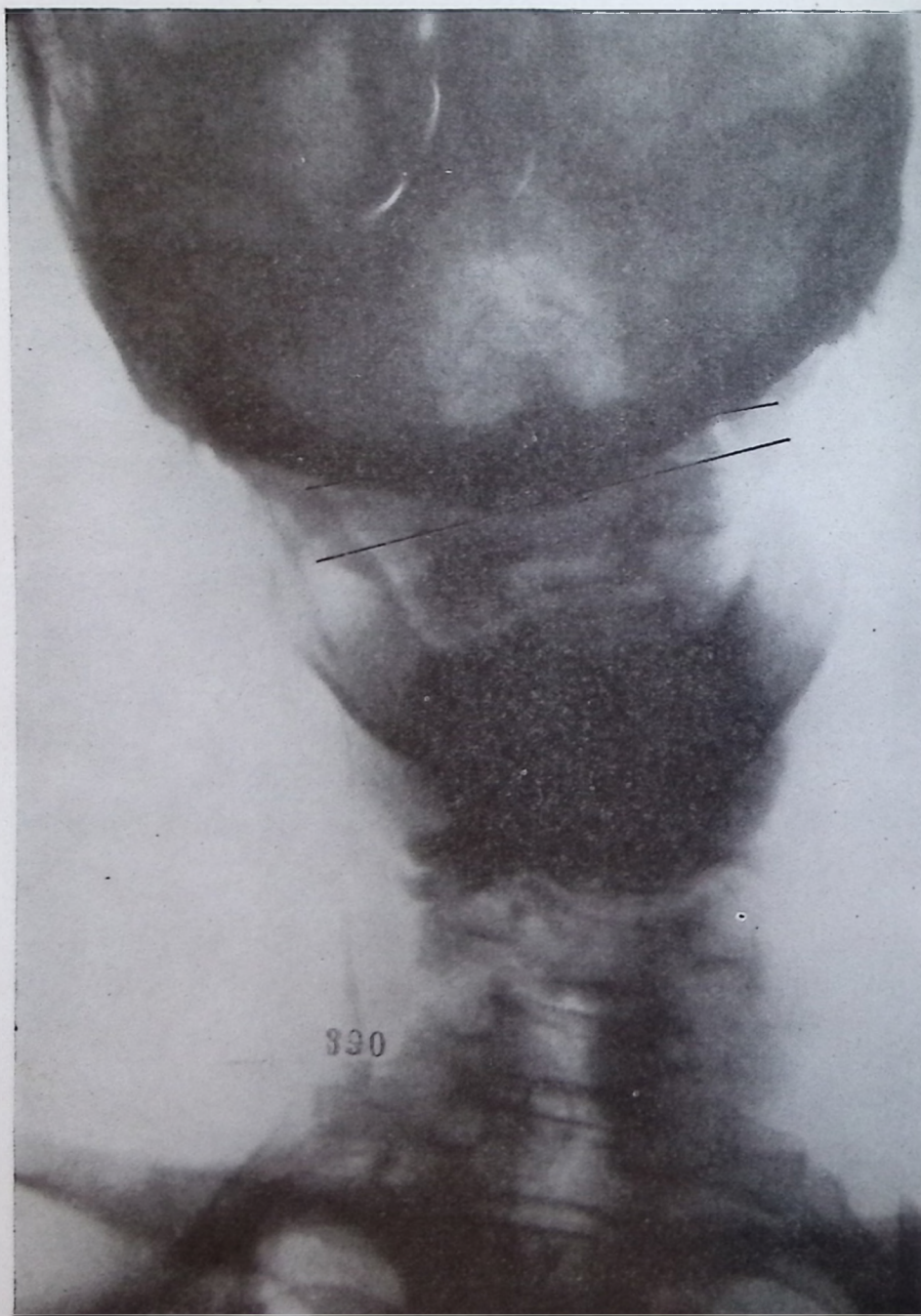


Illustration No. 390



Illustration No. 391

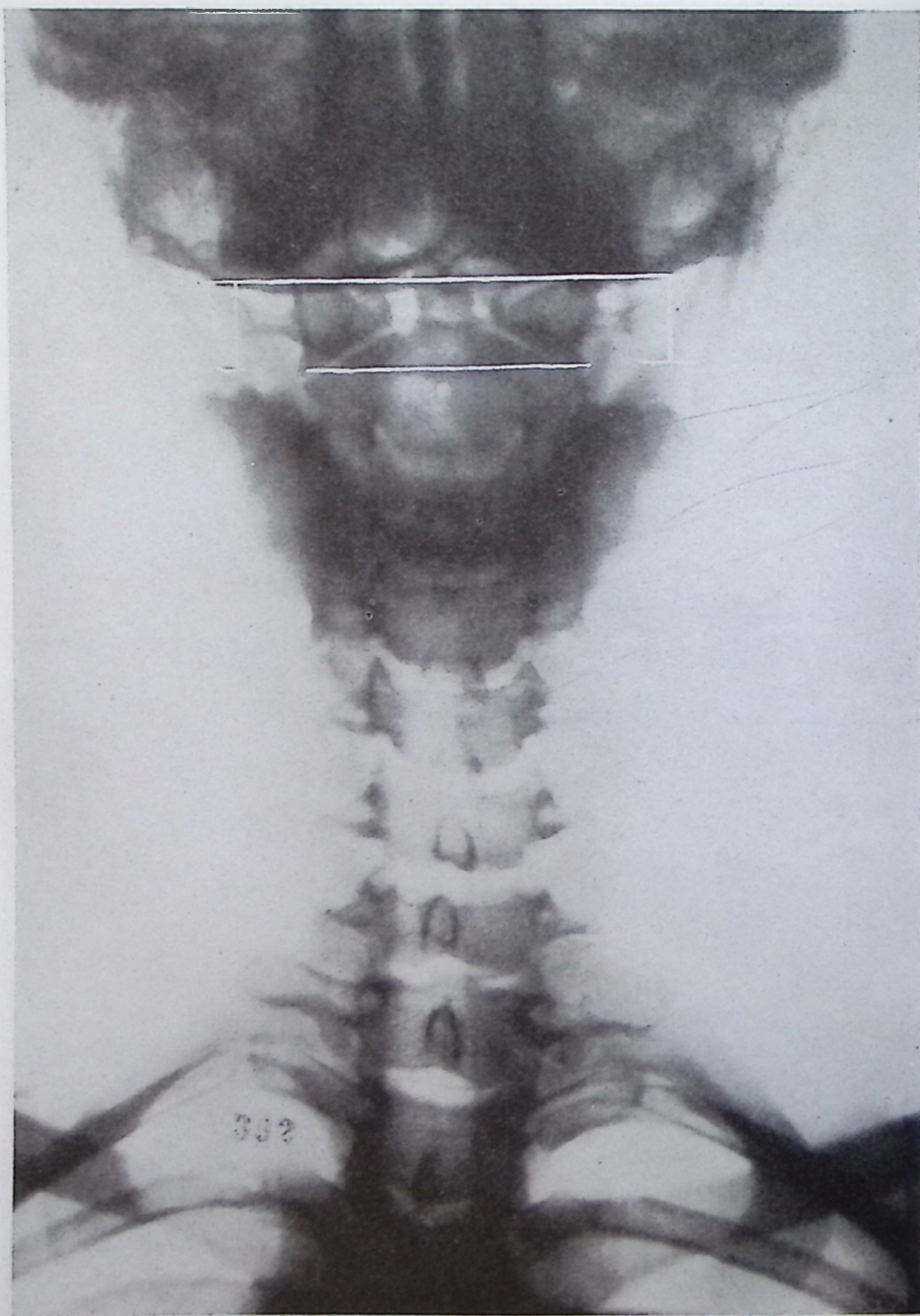


Illustration No. 392



Illustration No. 393

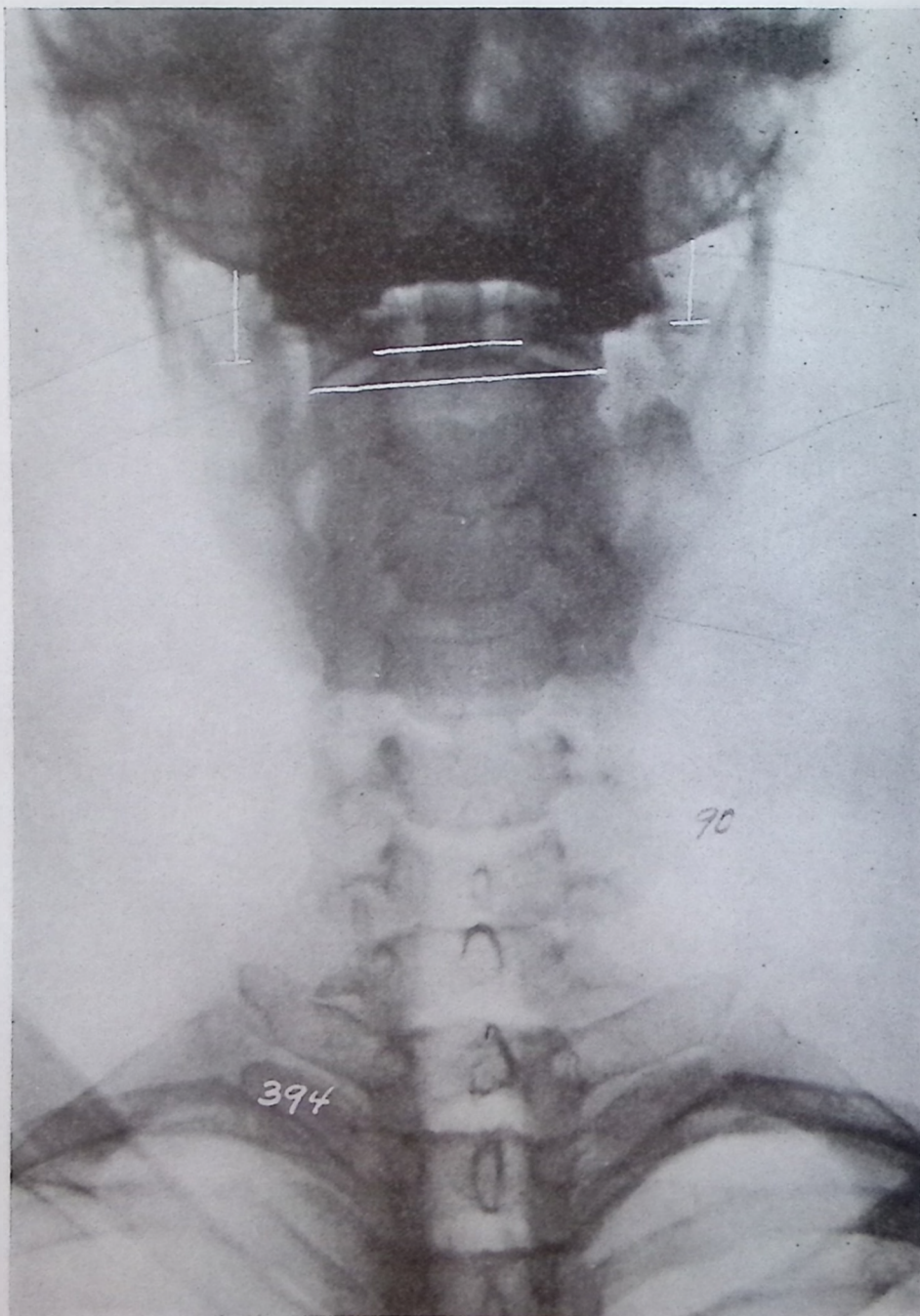


Illustration No. 394



Illustration No. 395

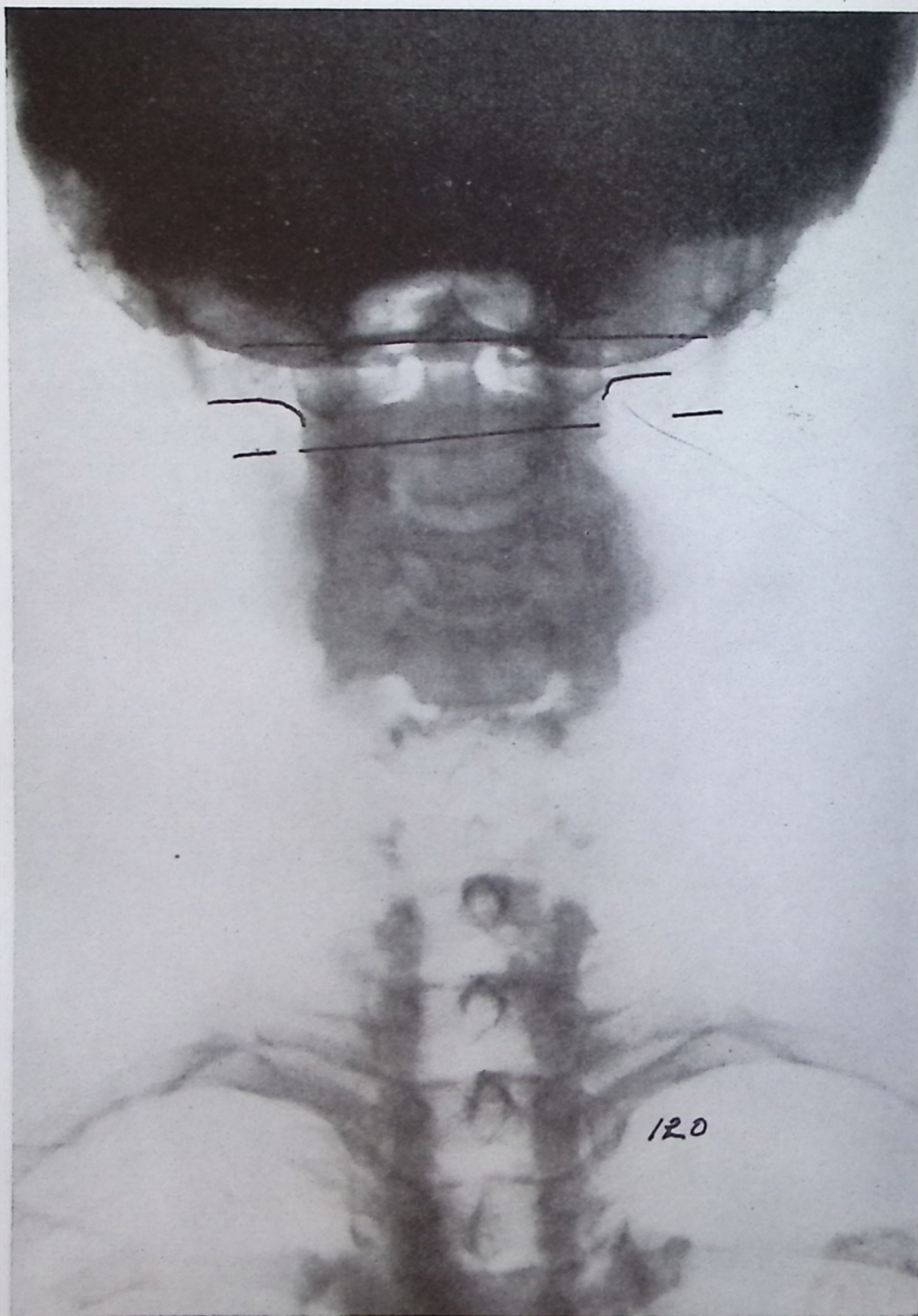


Illustration No. 396

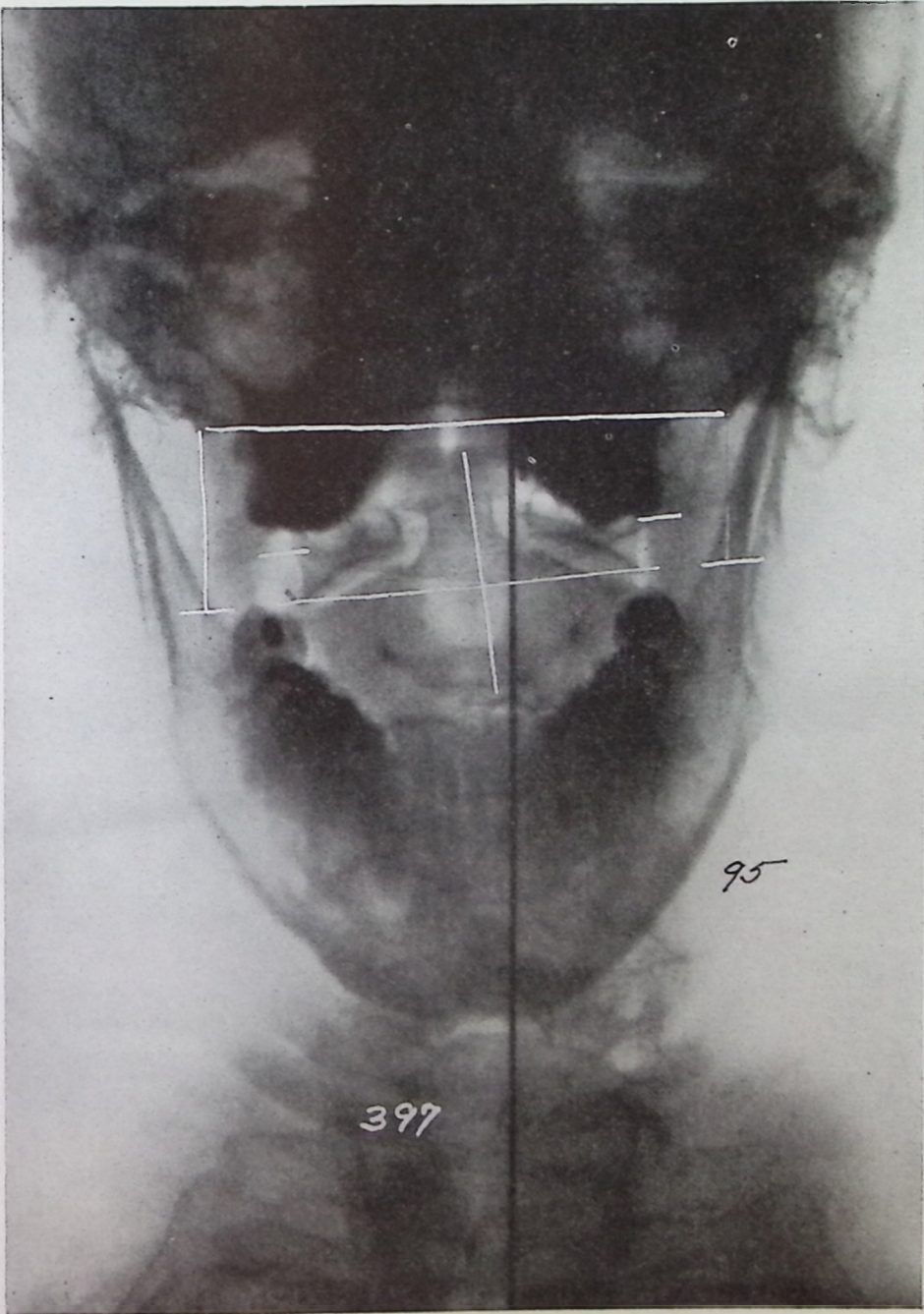


Illustration No. 397

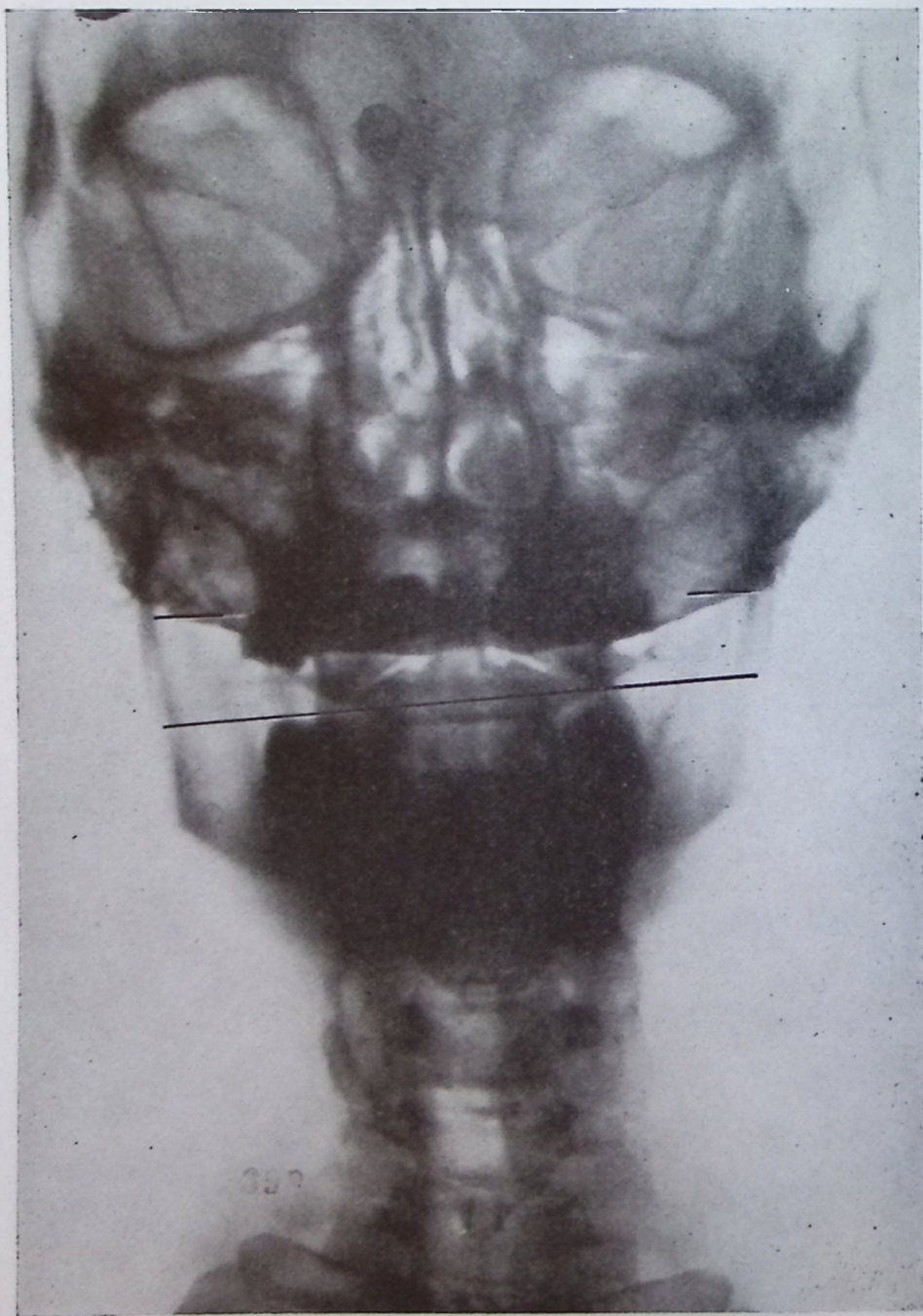


Illustration No. 398



Illustration No. 399



Illustration No. 400



Illustration No. 401

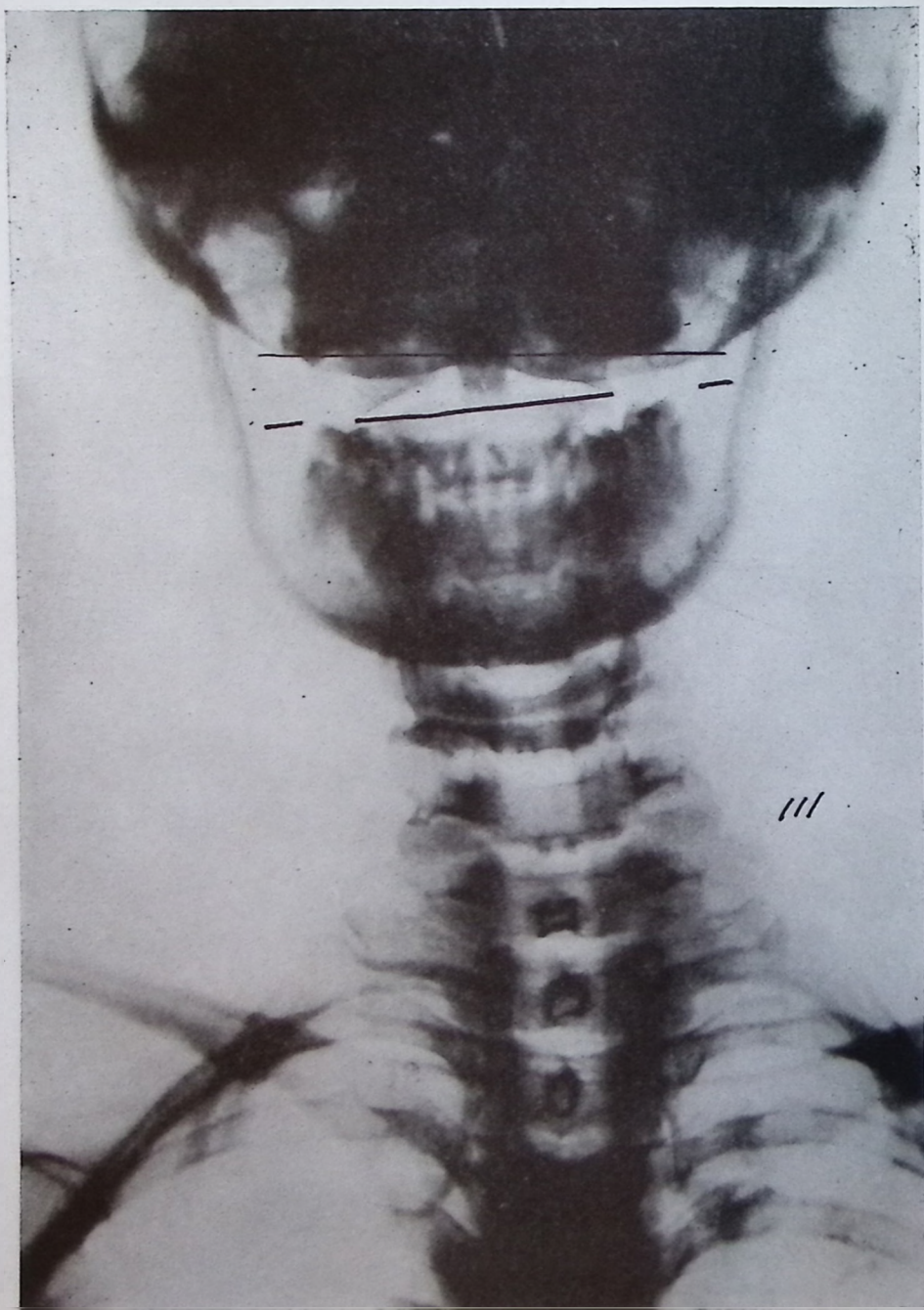


Illustration No. 402

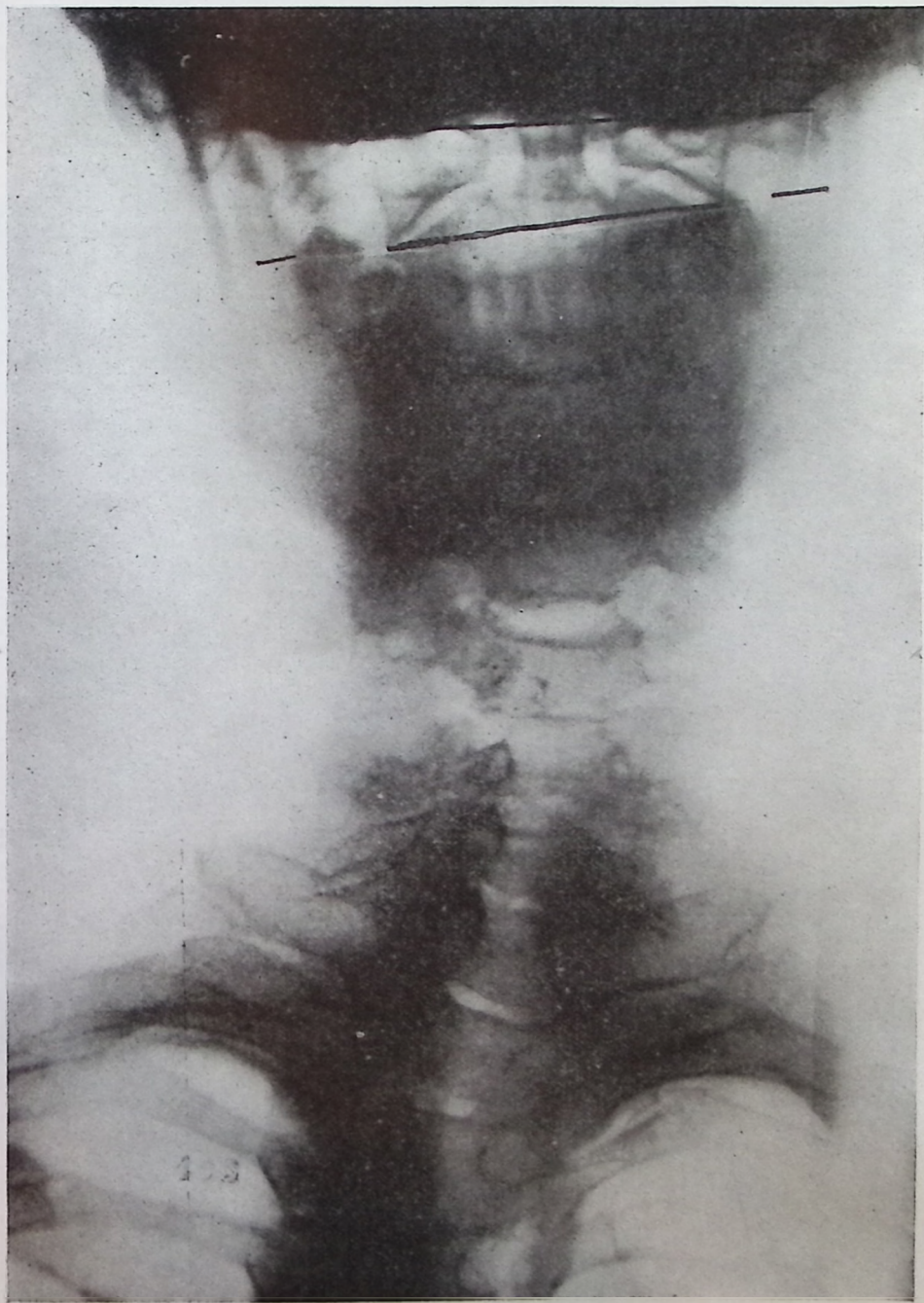


Illustration No. 403

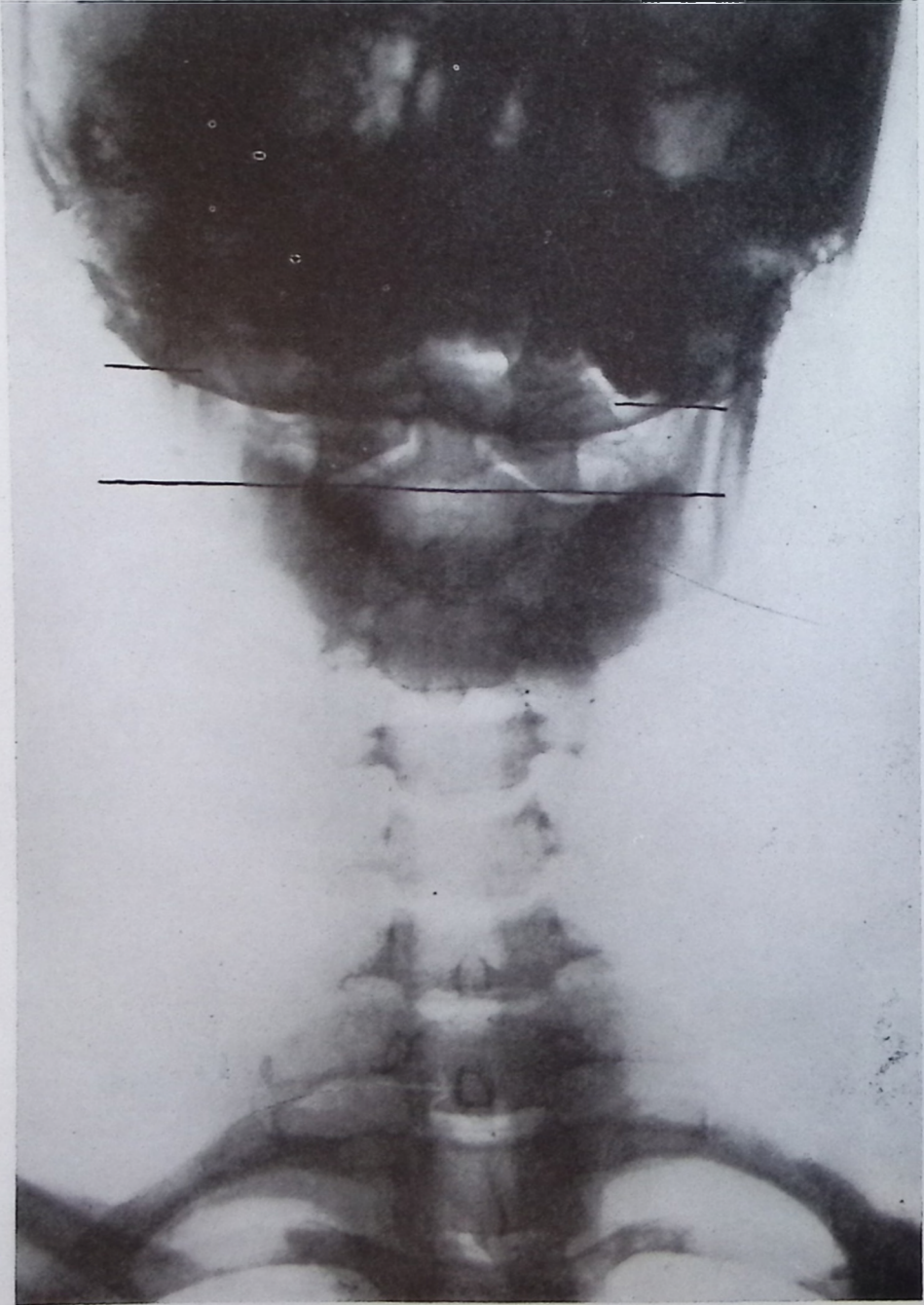


Illustration No. 404

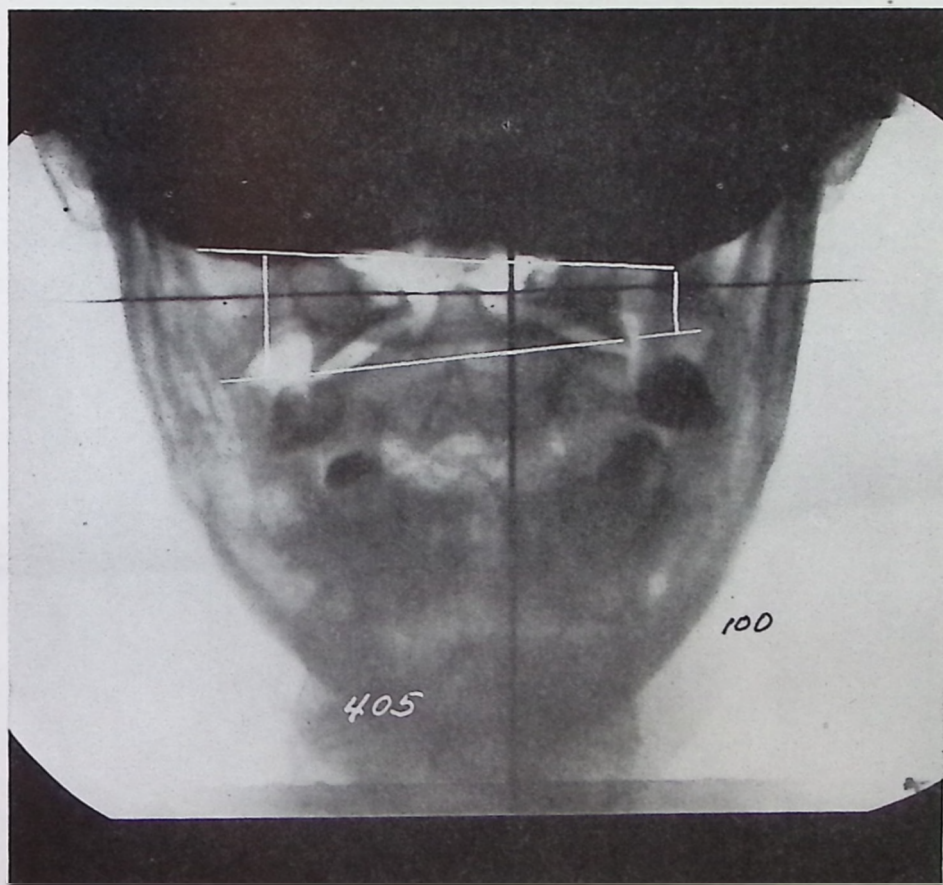


Illustration No. 405



Illustration No. 406

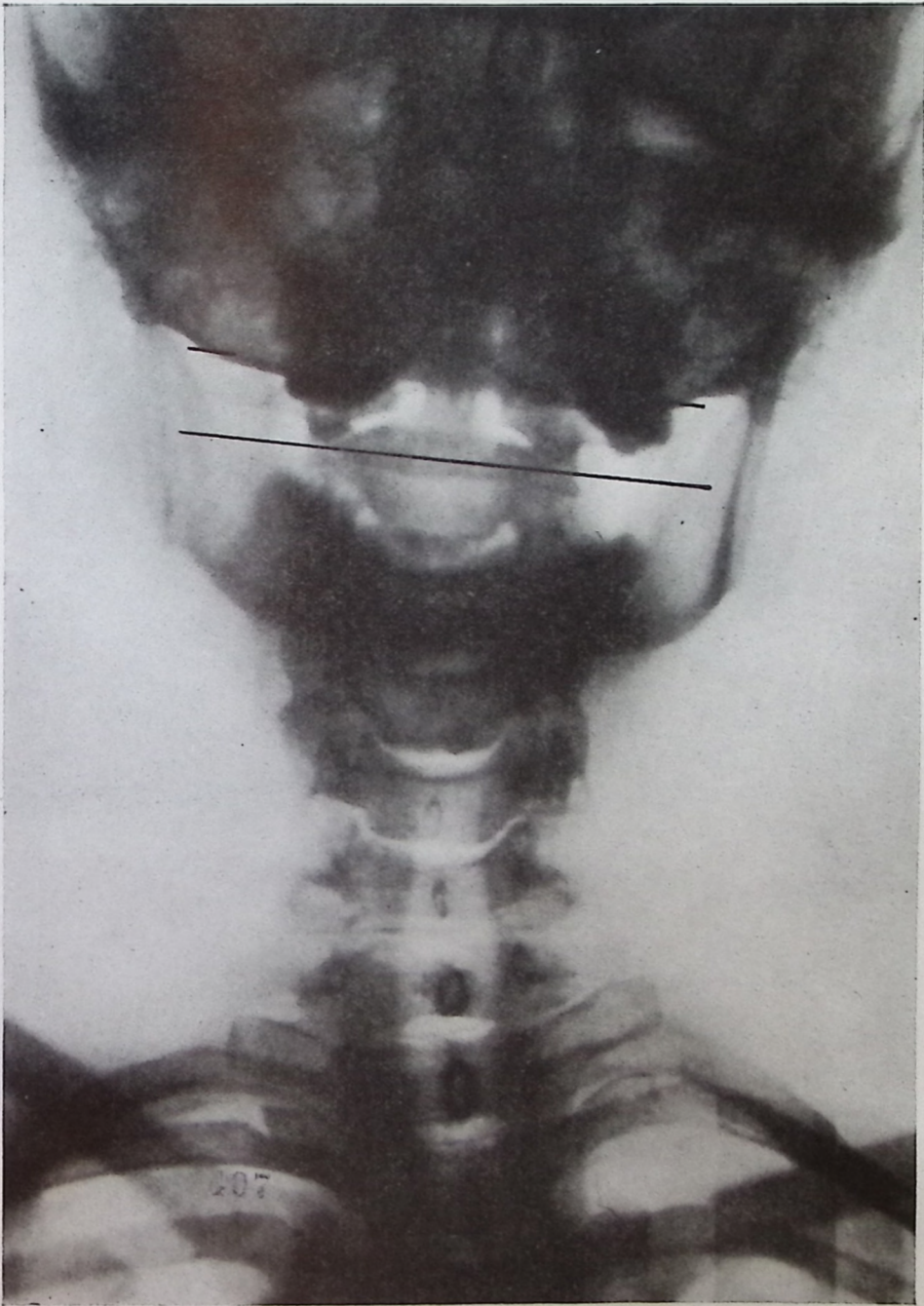


Illustration No. 407



Illustration No. 408

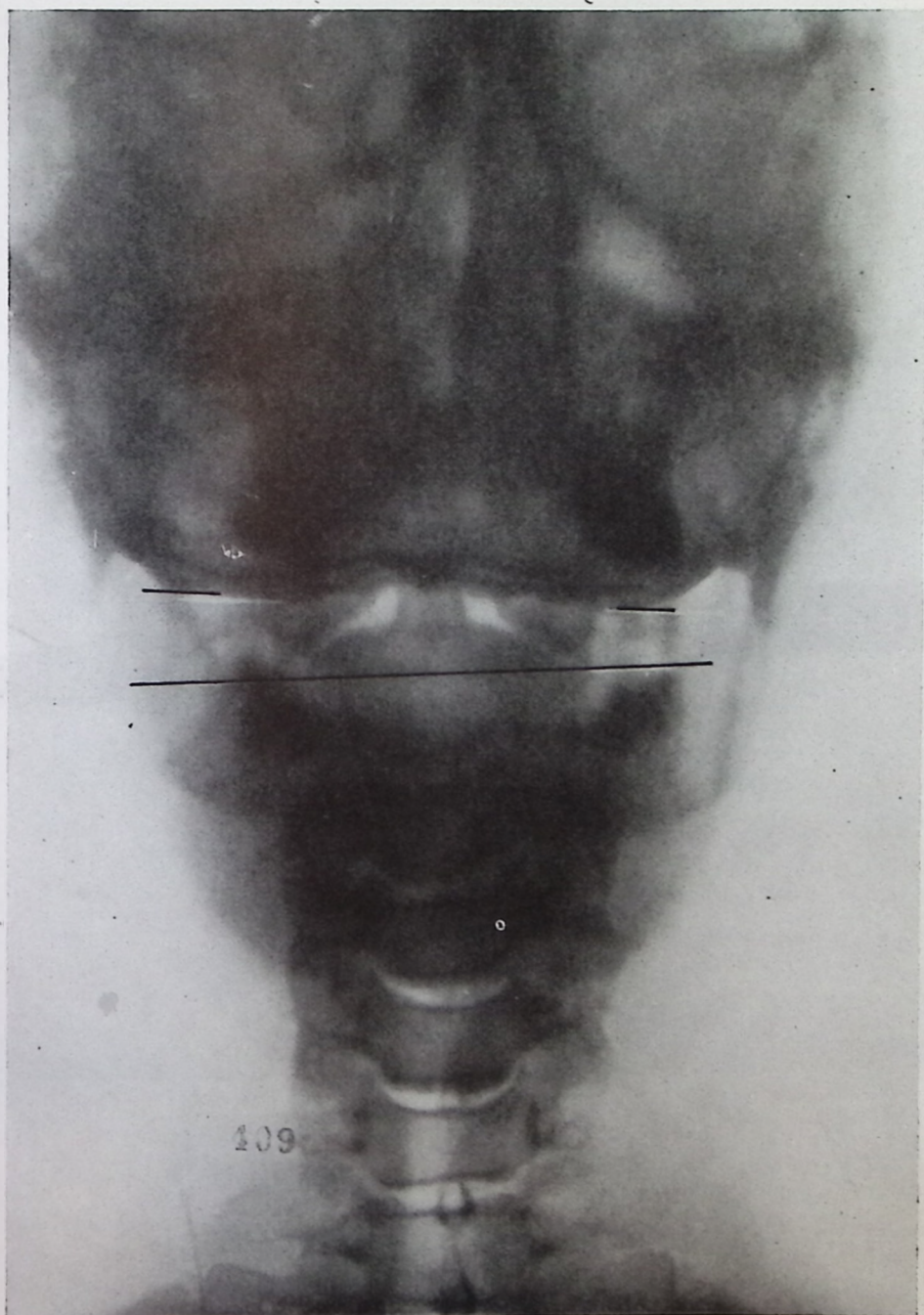


Illustration No. 409

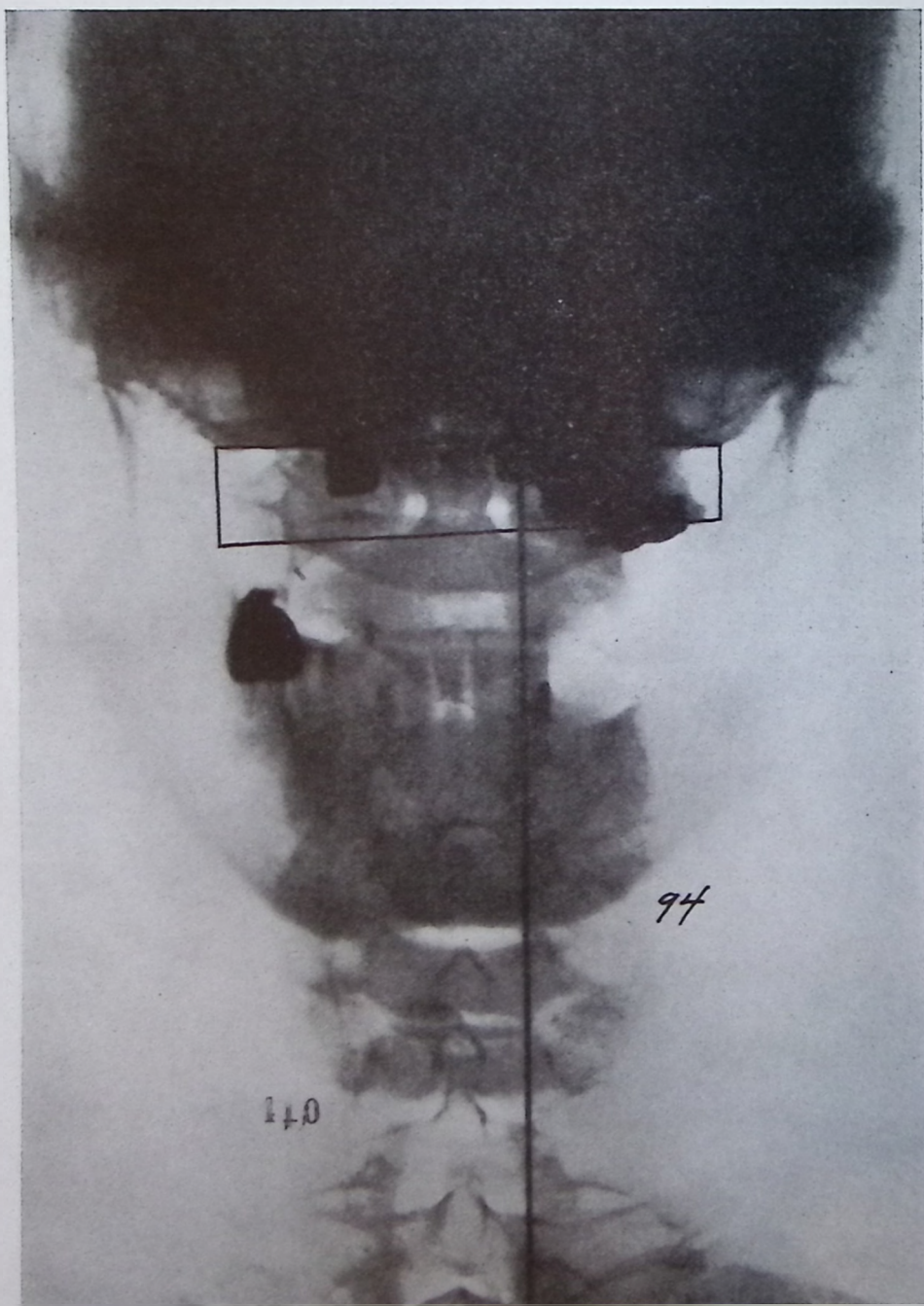


Illustration No. 410



Illustration No. 411

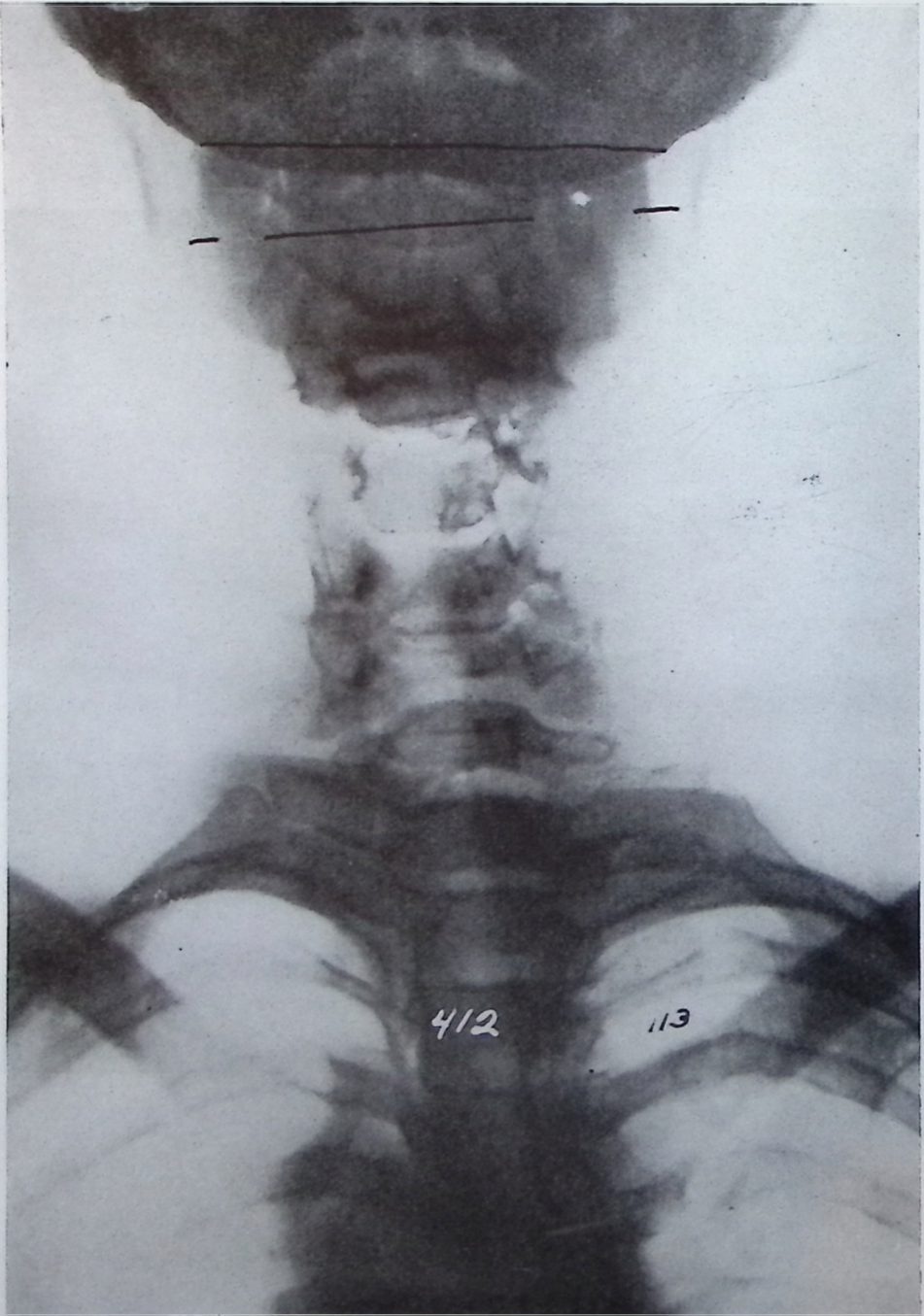


Illustration No. 412

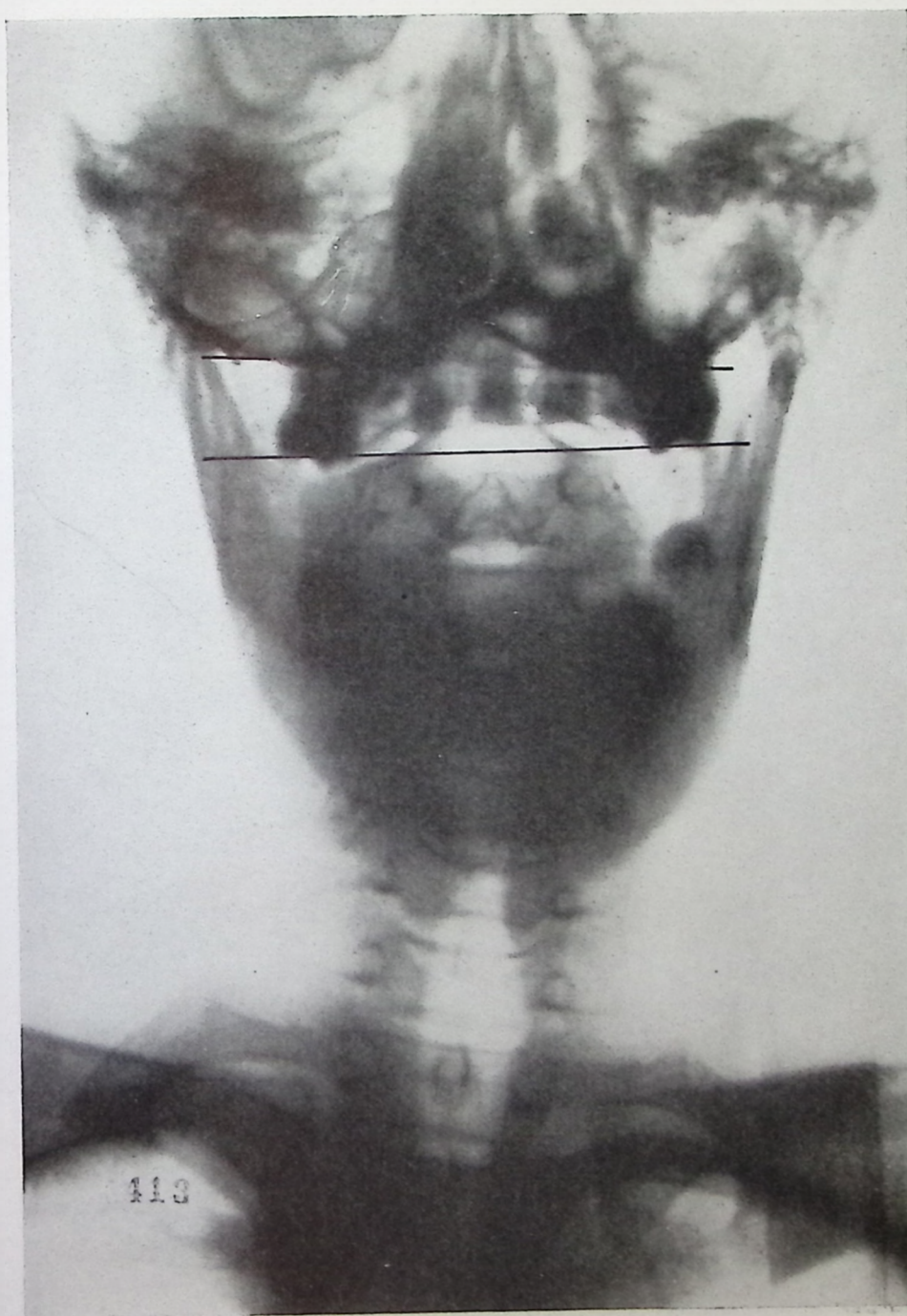


Illustration No. 413

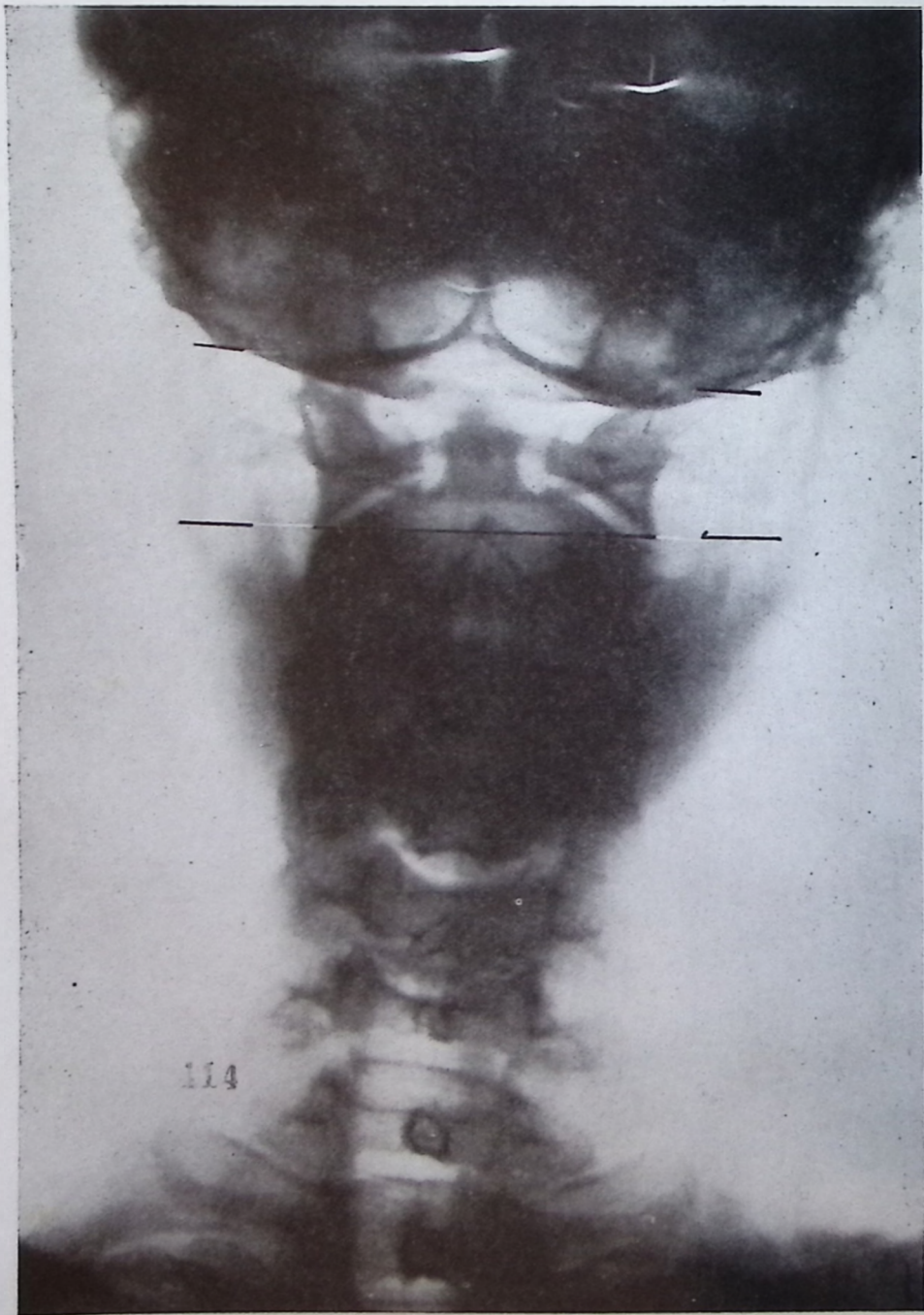


Illustration No. 414

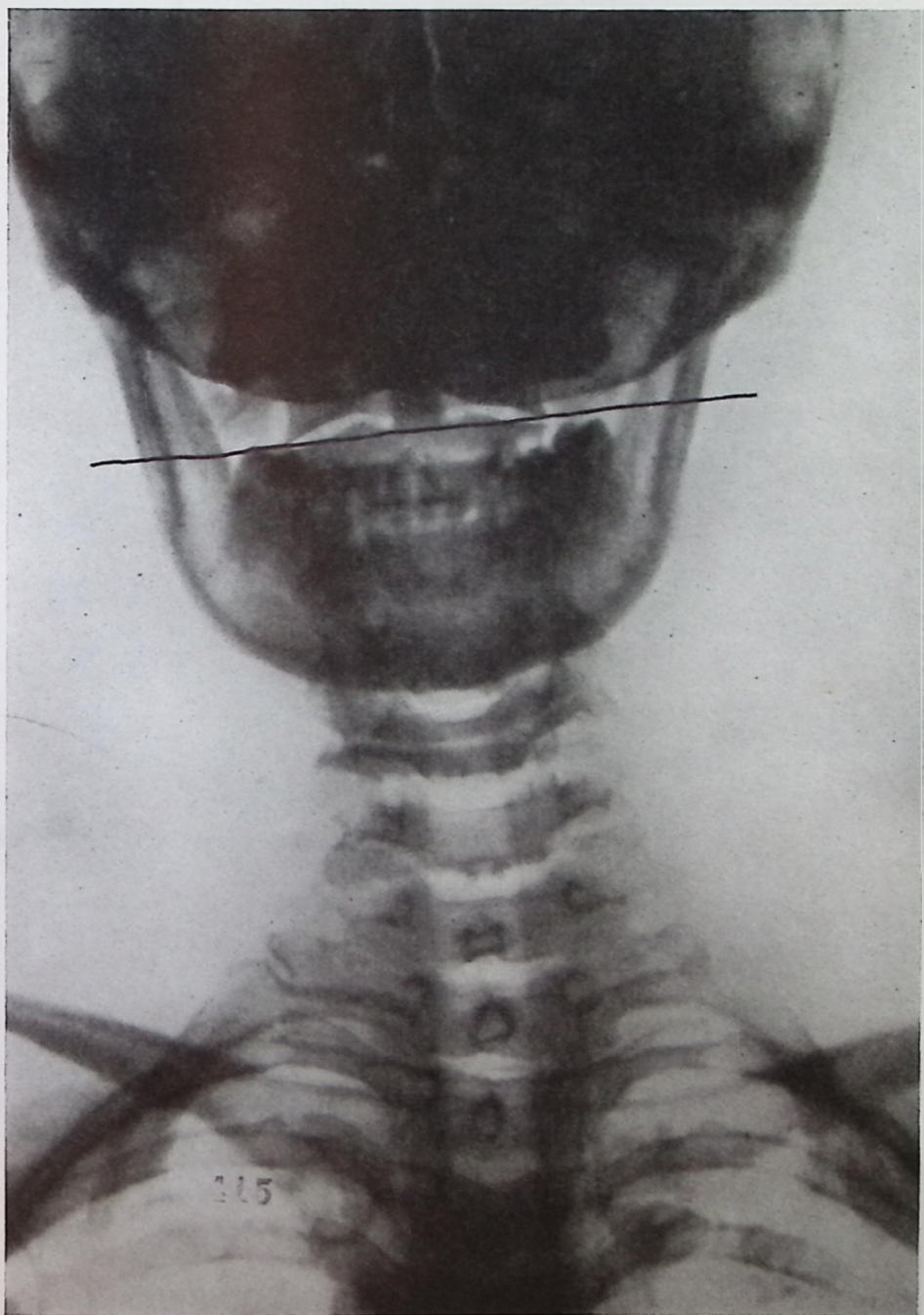


Illustration No. 415

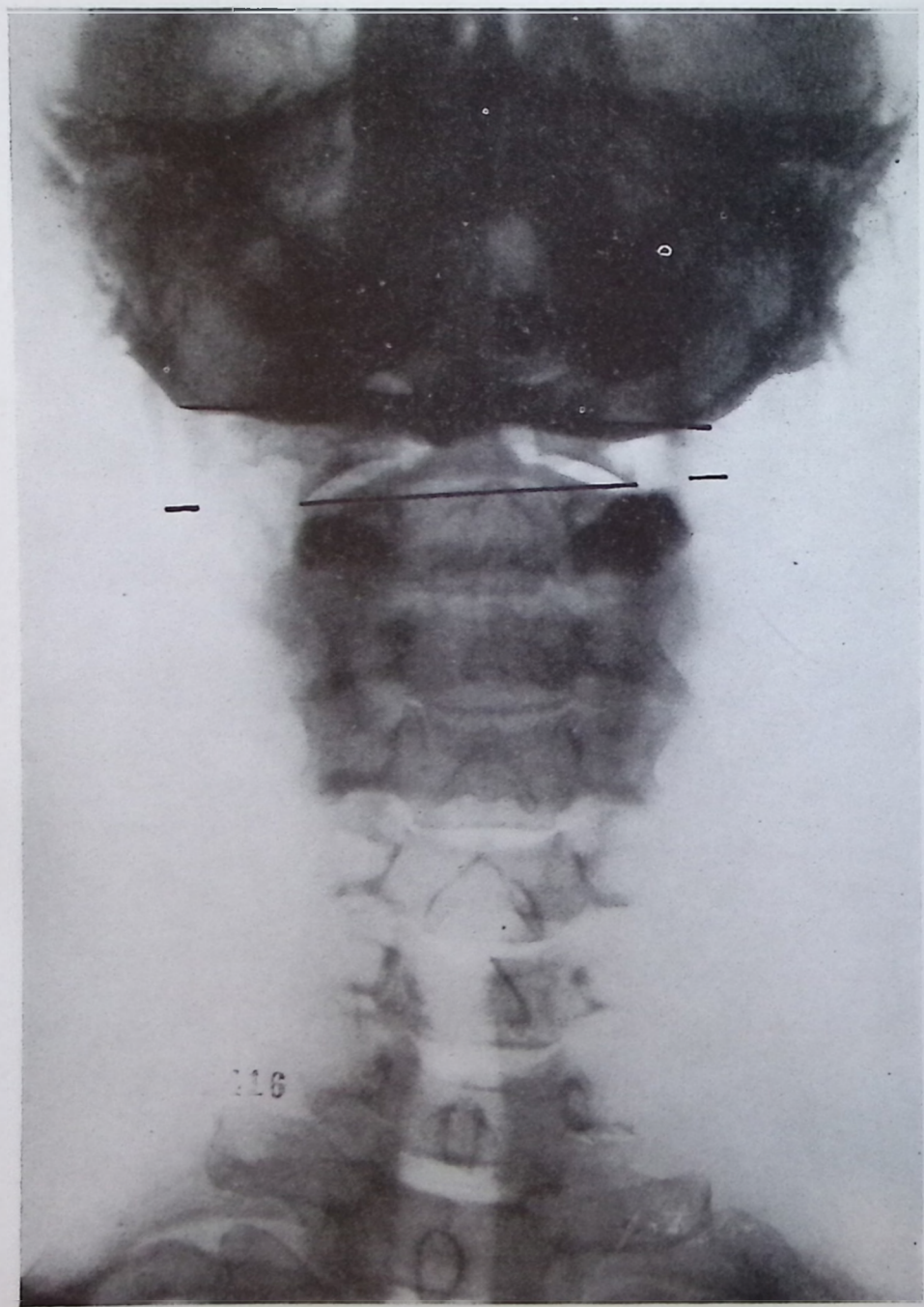


Illustration No. 416

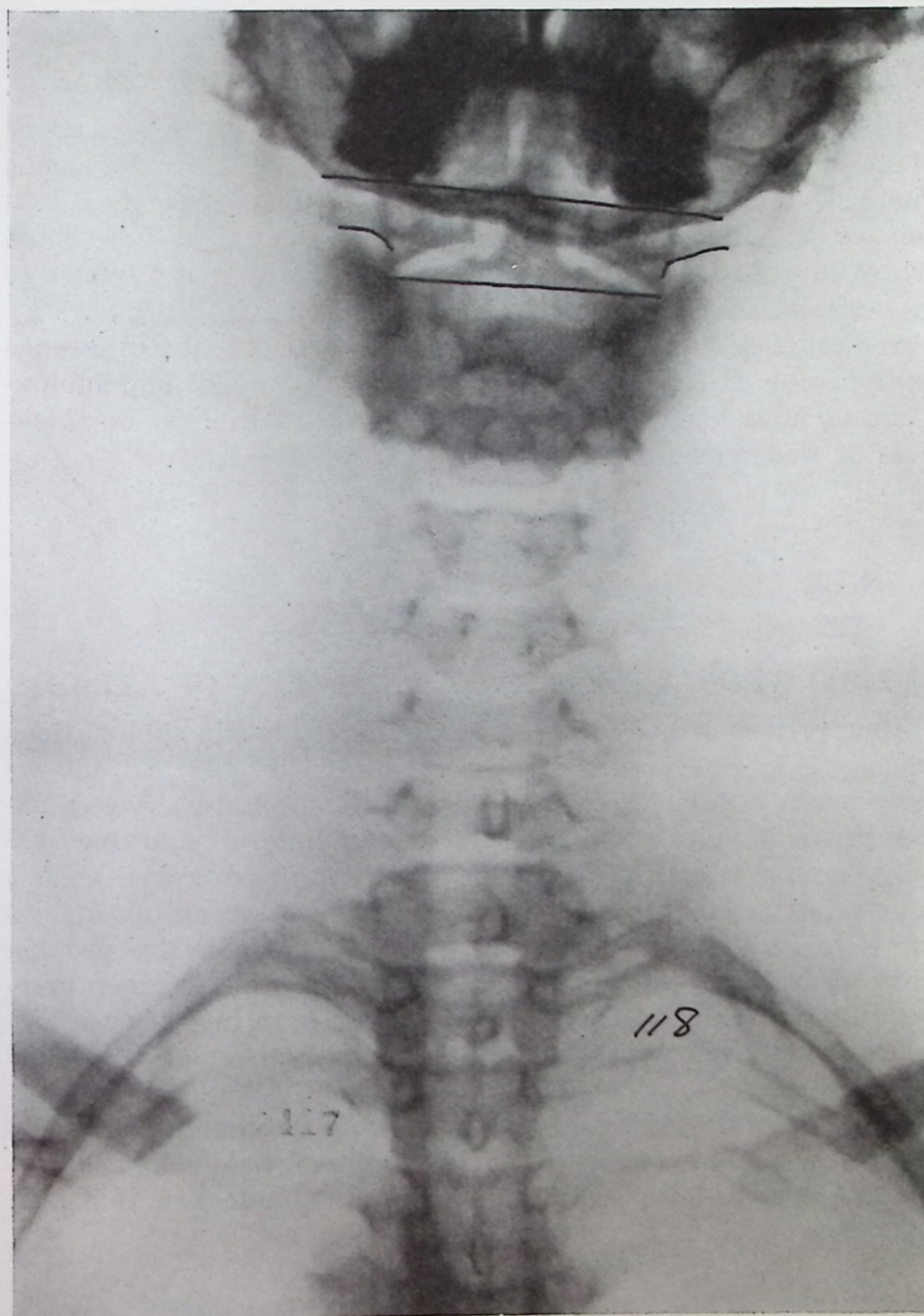


Illustration No. 417

CHAPTER XXXIX

L. HI WEDGE-SIDE-SLIP SUBLUXATIONS OF ATLAS

Illustrations 418 to 428 are L. HI wedge-side-slip subluxations of atlas. In this group we have portrayed A-P spinographic views. Lateral views would follow previous rules. For that reason we do not here give complete listing. L. HI as here illustrated might be ASL or AIL. We have portrayed A-P views to give plane lines and to show wedge shape on L.

We commend to your attention varying degrees of difference as to degree of "HI" as well as degree of wedge-side-slip subluxation of atlas as suggested by differences in thinness or thickness of wedge on L.

CHAPTER XL

L. LO WEDGE-SIDE-SLIP SUBLUXATIONS OF ATLAS

Illustrations 429 to 445 are L. LO wedge-side-slip subluxations of atlas. In this group, with exception of No. 429 and 430 we have portrayed only A-P spinographic views. Lateral views follow previous rules. We have introduced lateral view No. 429 only because it was the mate to No. 430 and portrayed such a marked extreme of position of odontoid process back into neural canal in addition to its marked L. LO wedge-side-slip proving that we can have both lateral inter-magnum-atlas foramen pressure as well as odontoid neural canal pressure in one case. In balance we have portrayed only A-P views to give plane lines and to show wedge-shape on L.

We commend your attention to varying degree of differences as to degree of "LO" as well as degree of wedge-side-slip subluxation of atlas as suggested by difference in thinness or thickness of wedge on L.

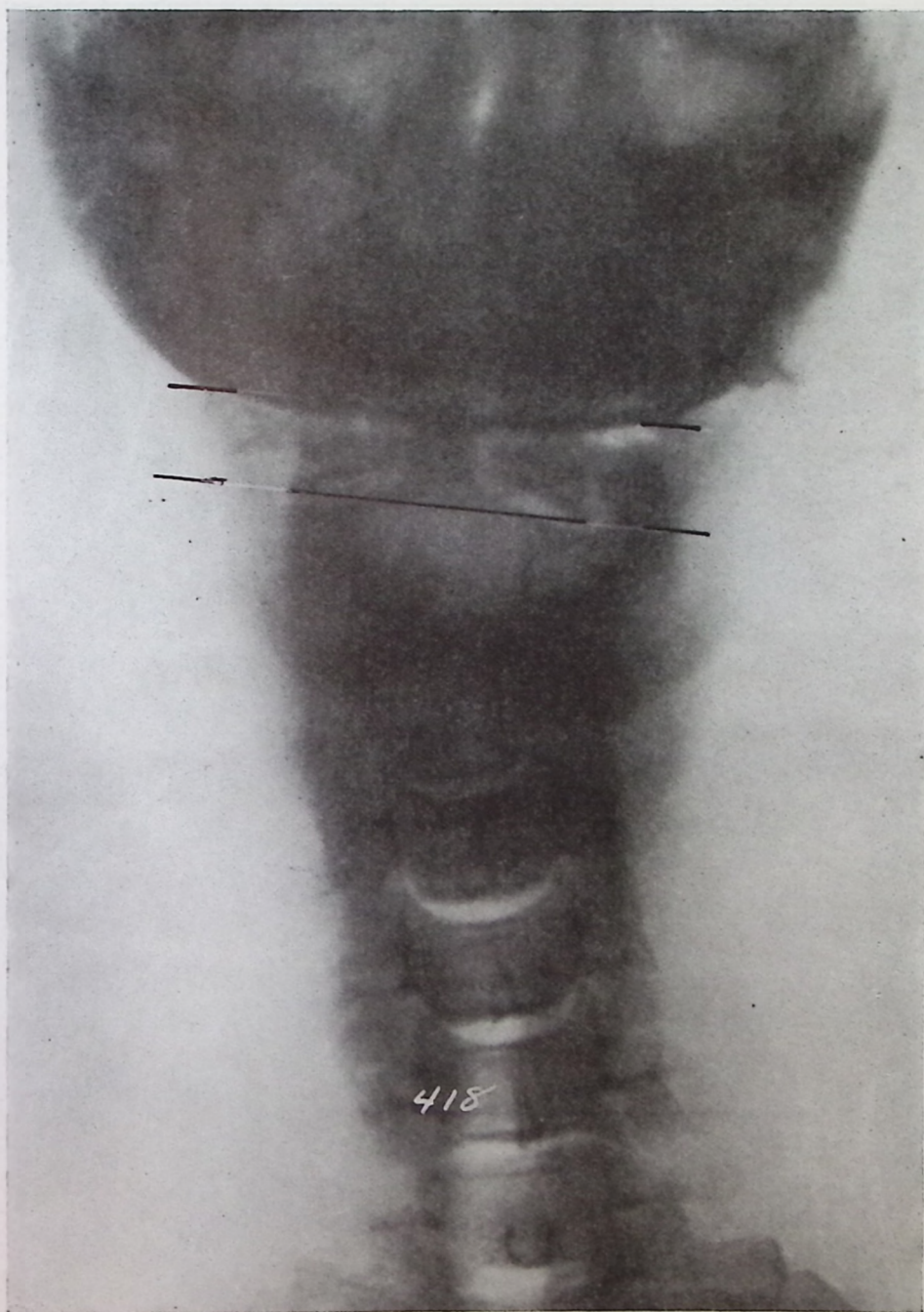


Illustration No. 418

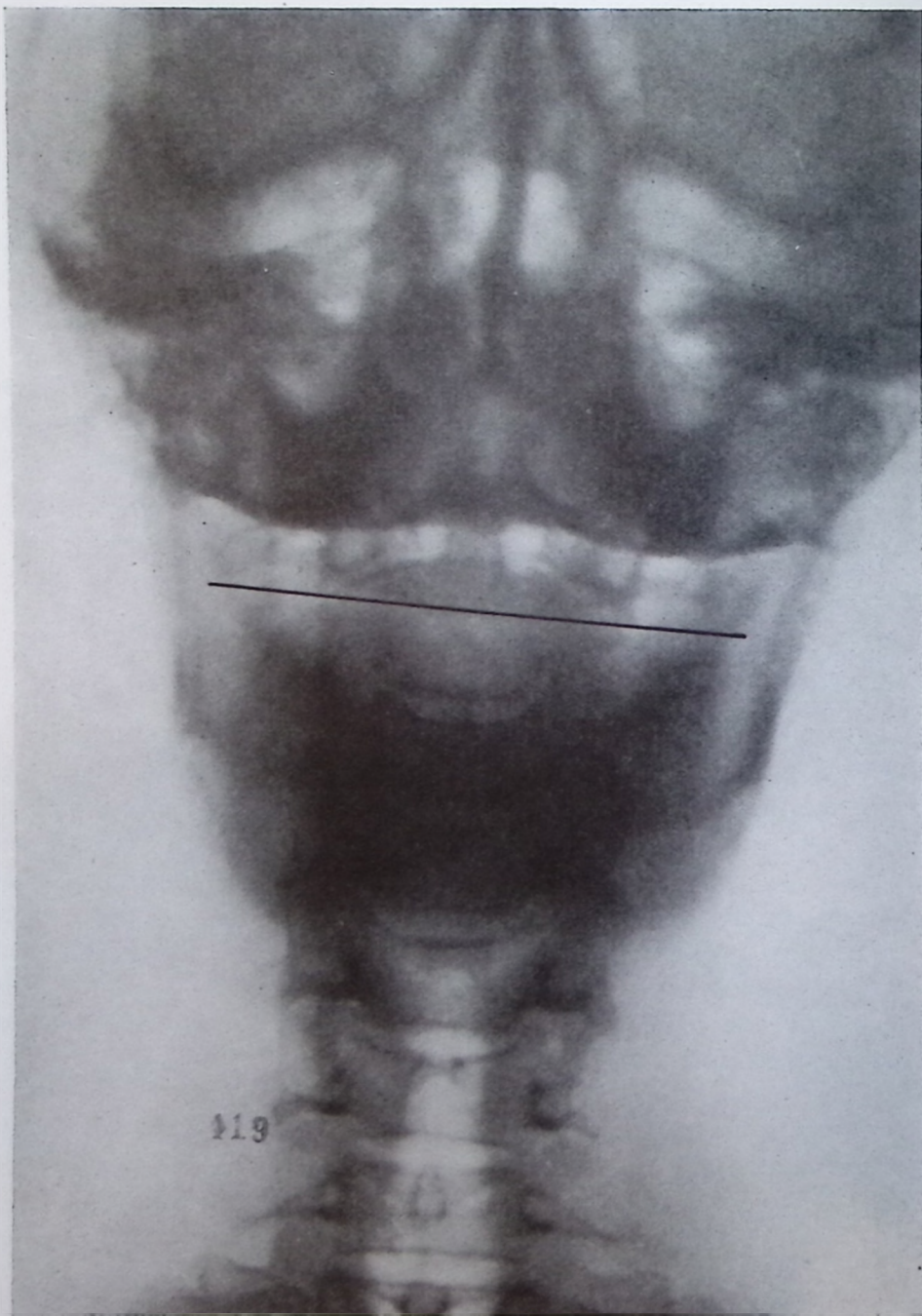


Illustration No. 419

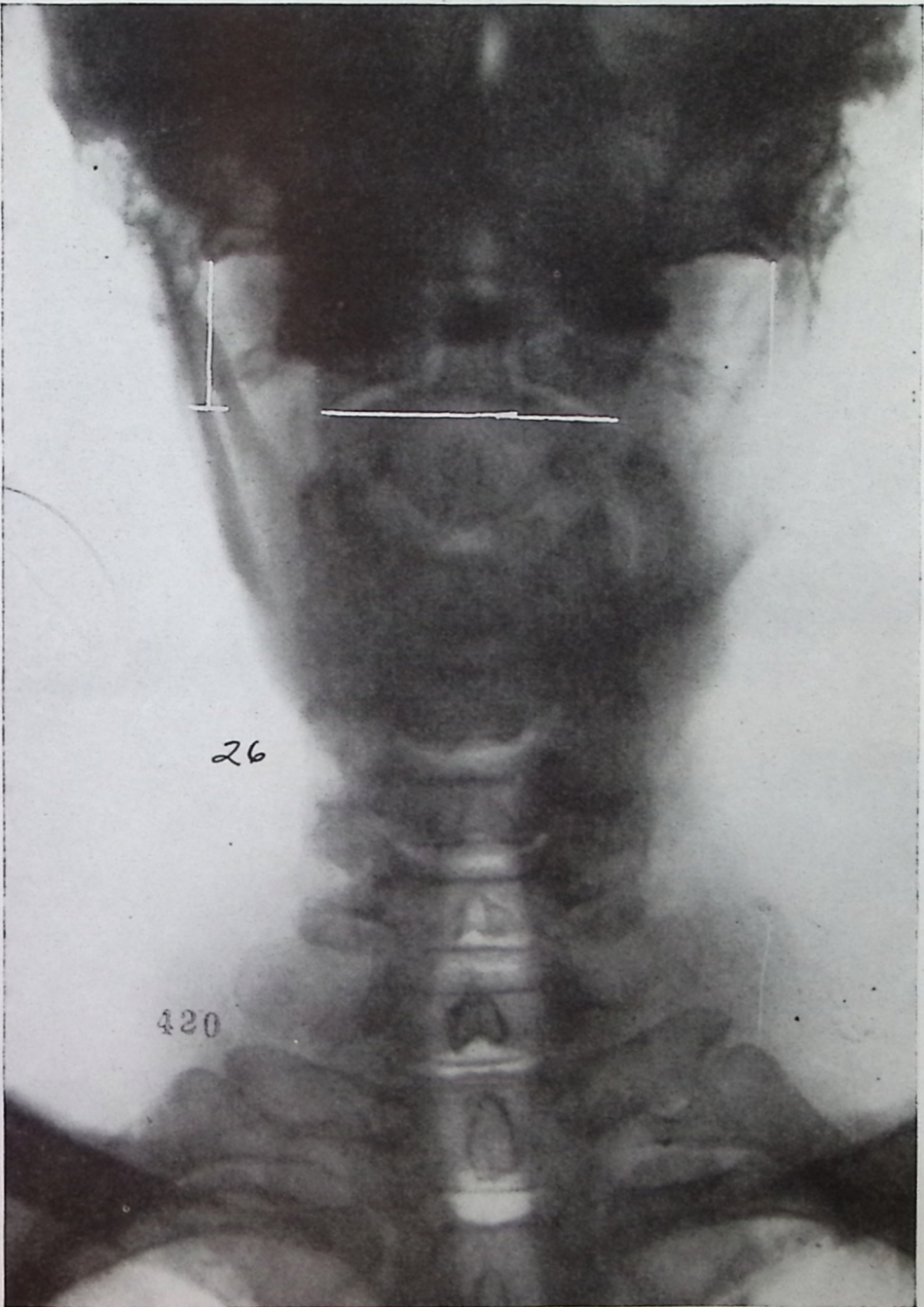


Illustration No. 420

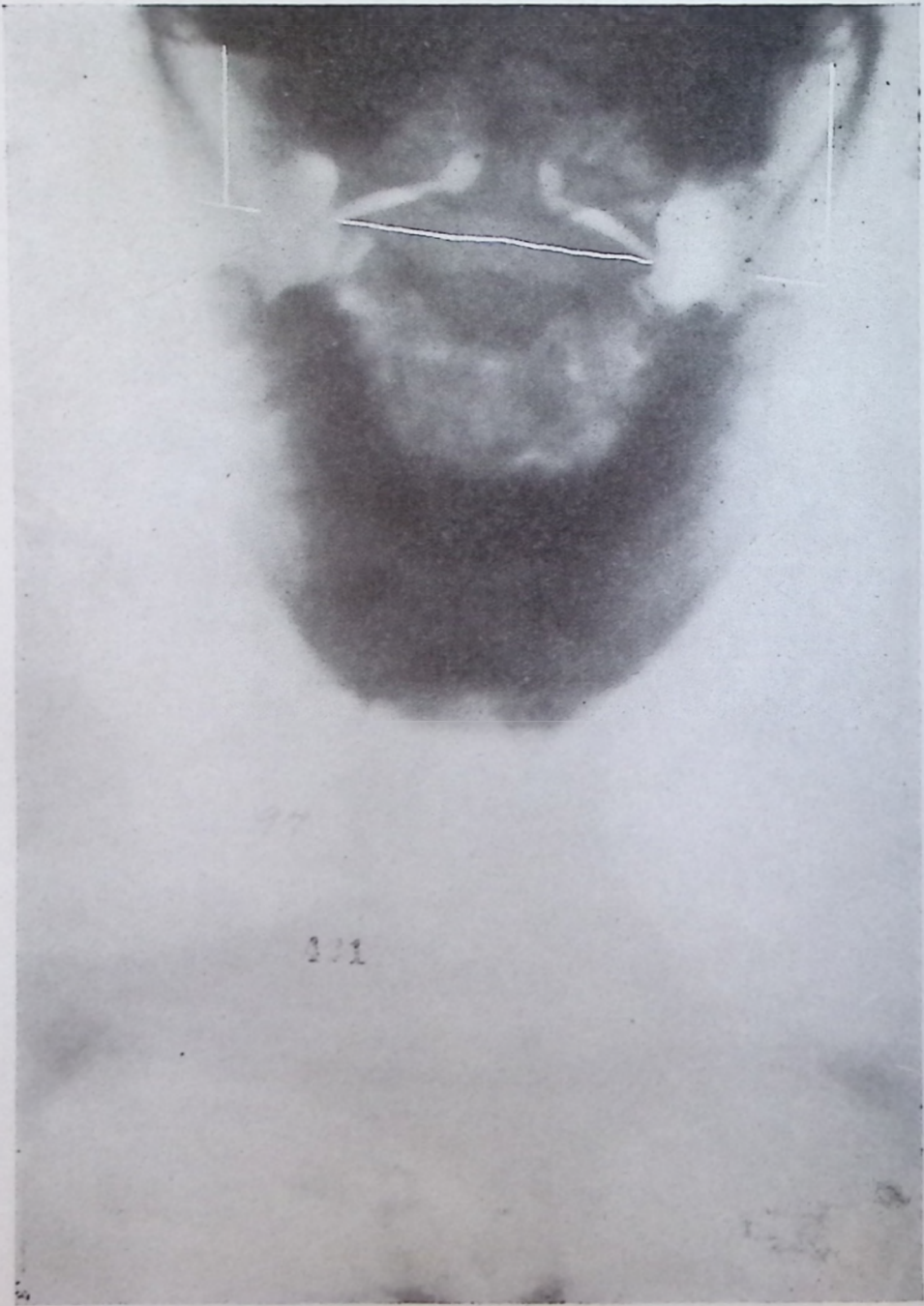


Illustration No. 421

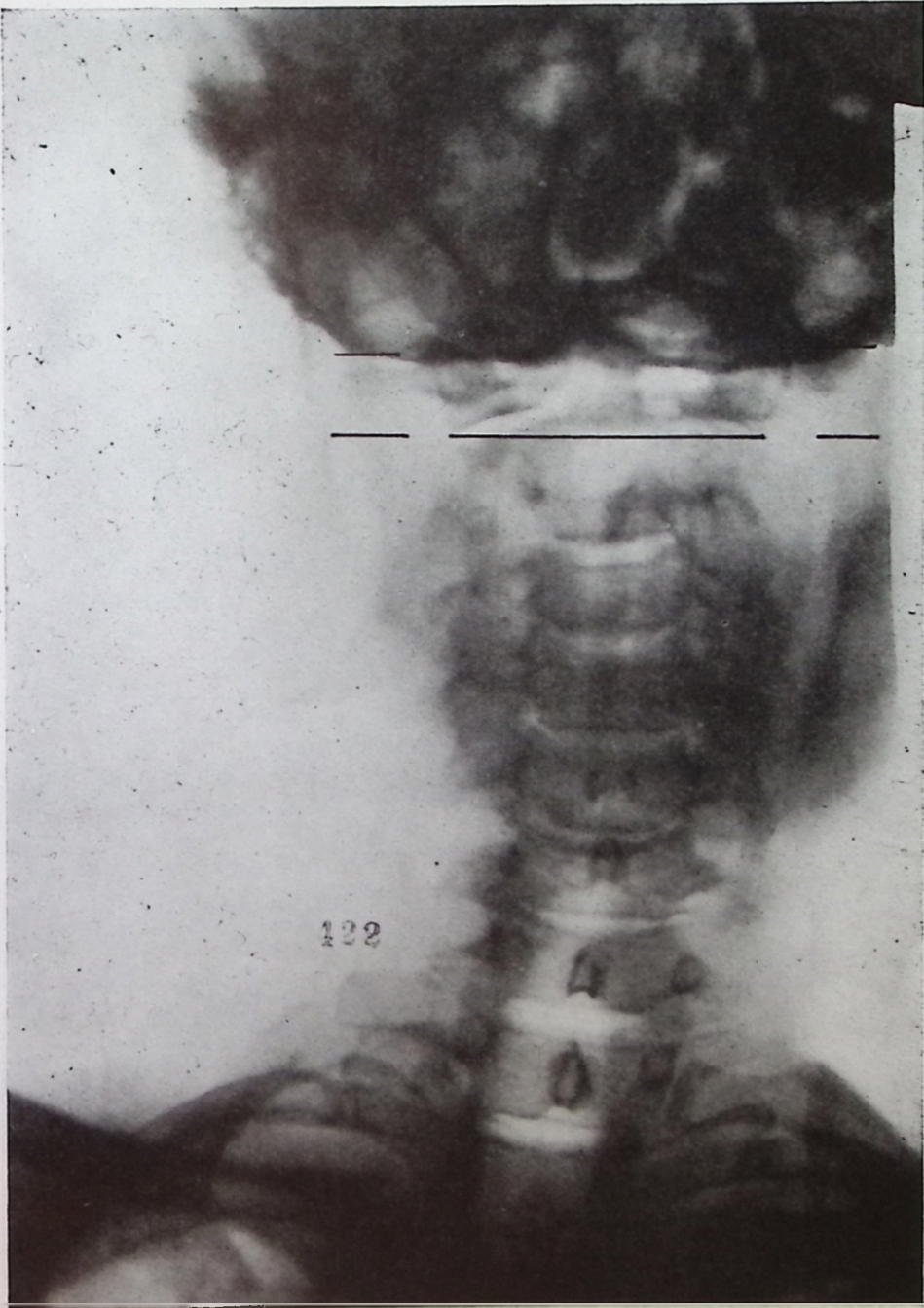


Illustration No. 422

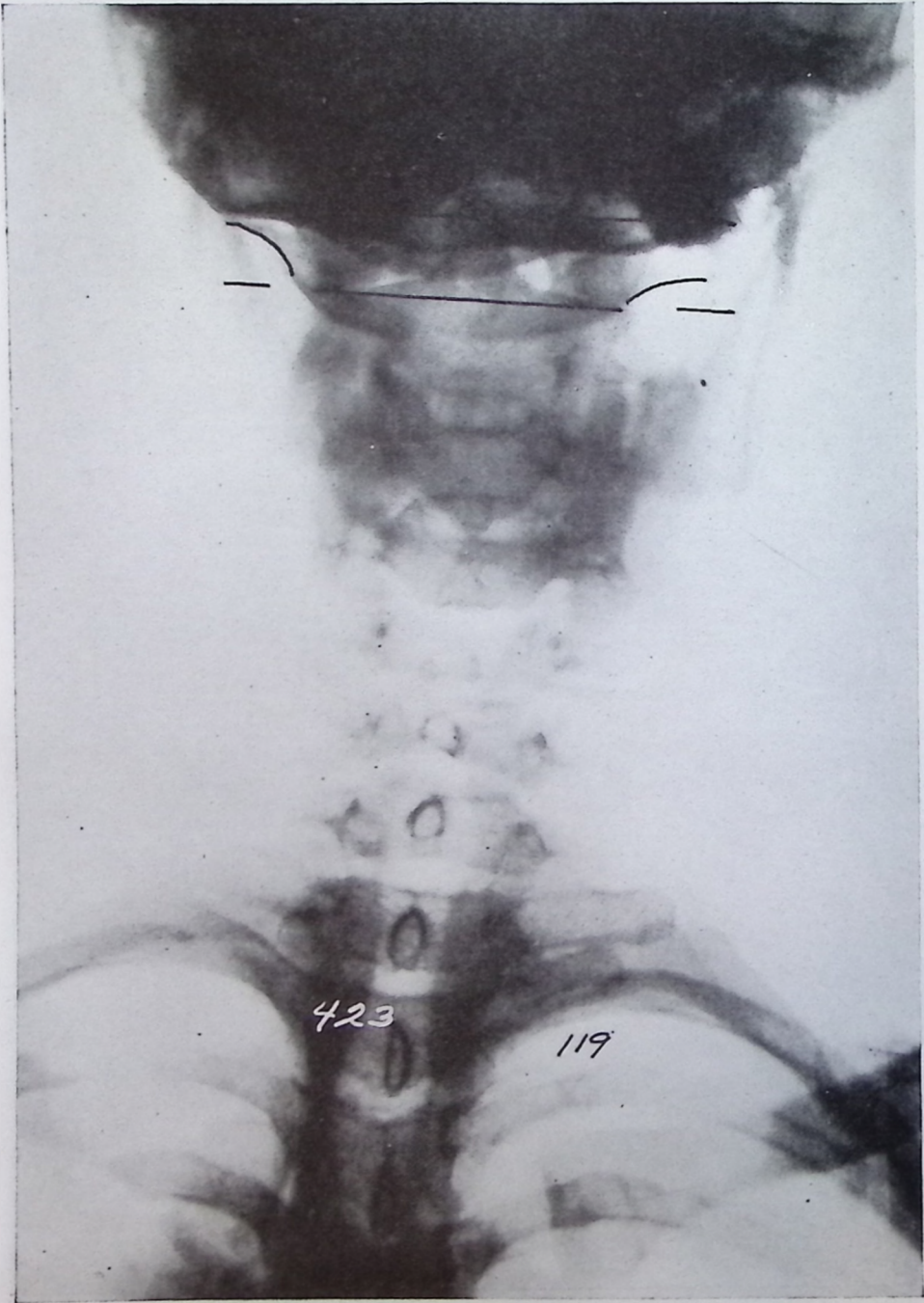


Illustration No. 423

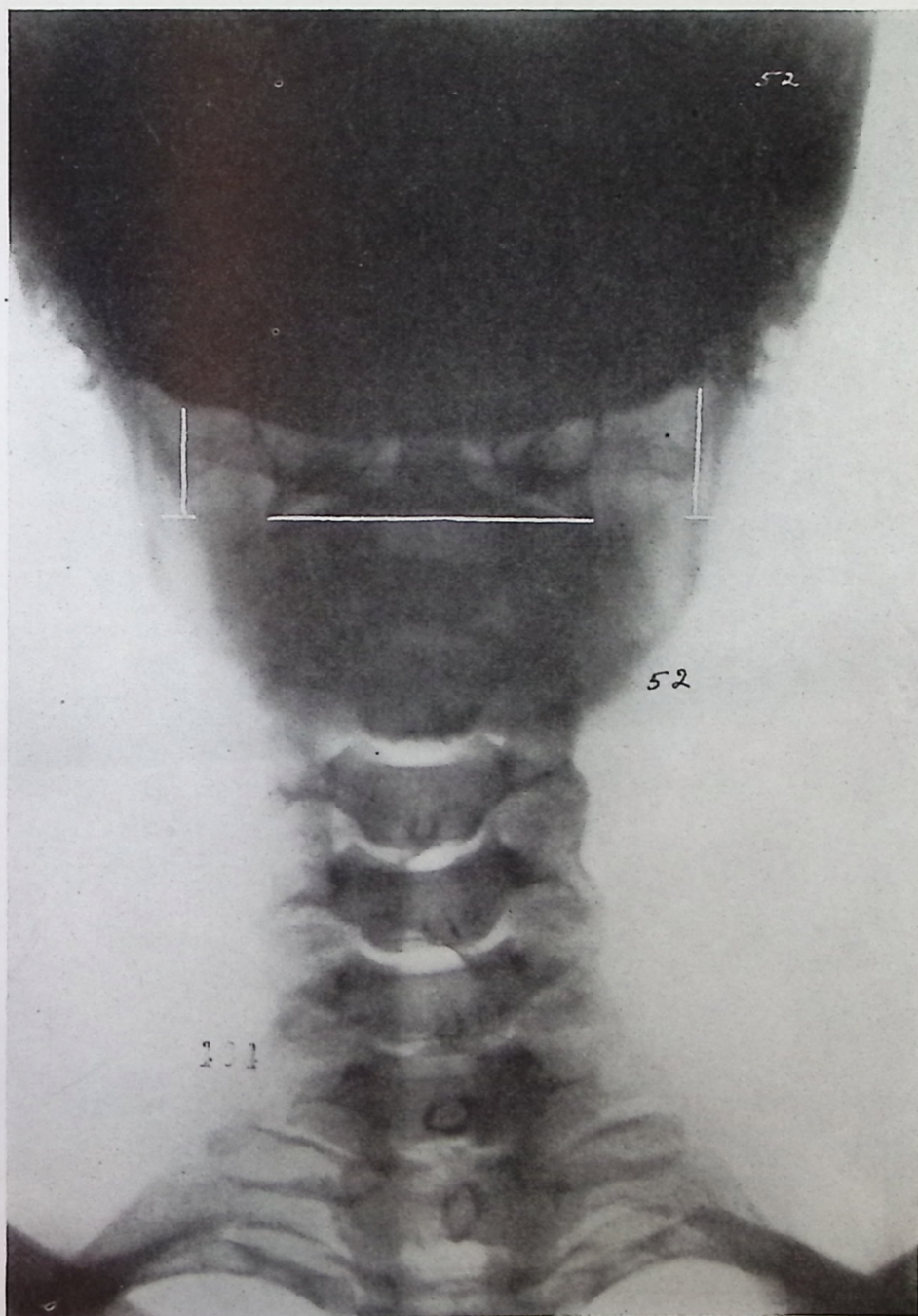


Illustration No. 424

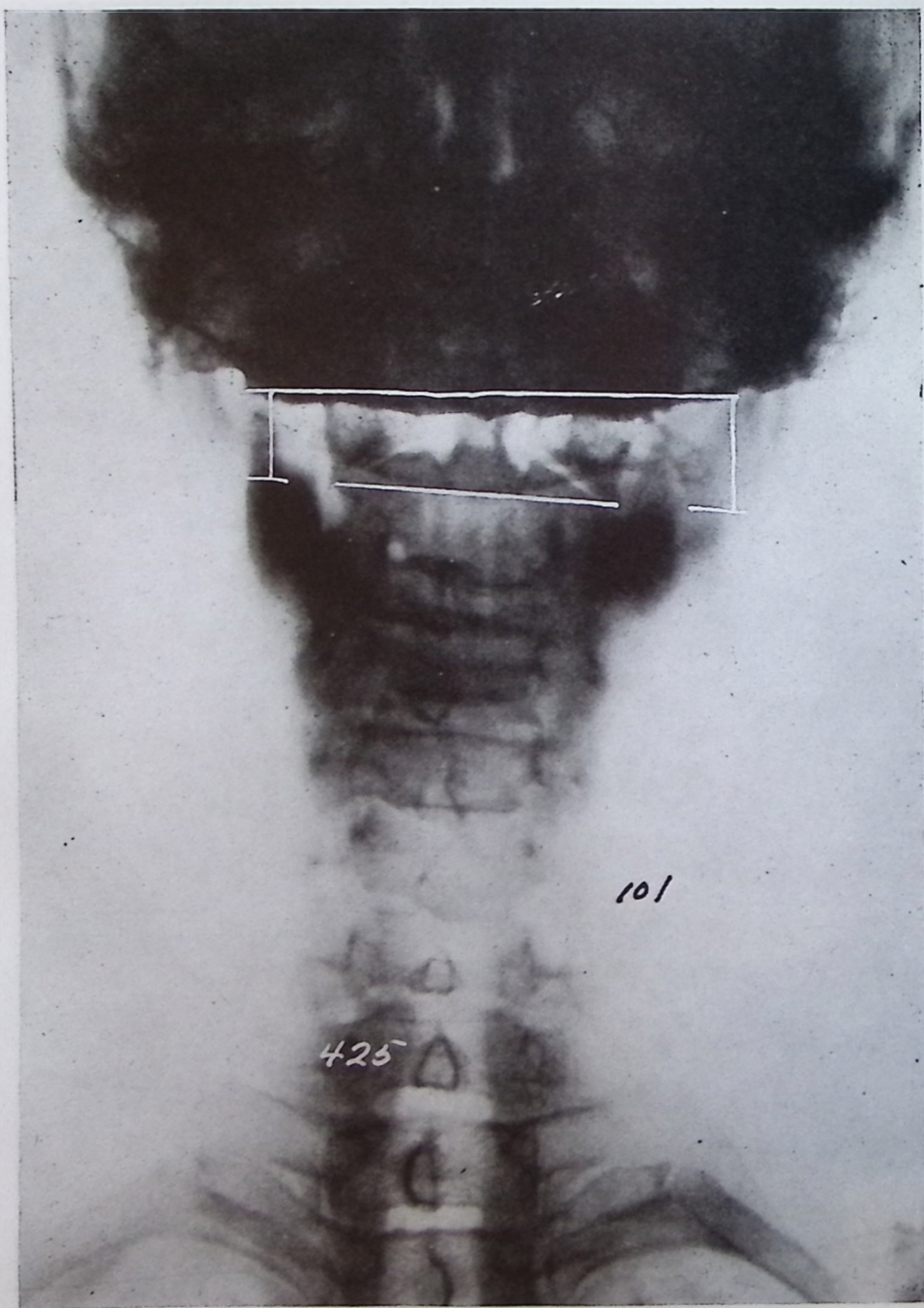


Illustration No. 425



Illustration No. 426

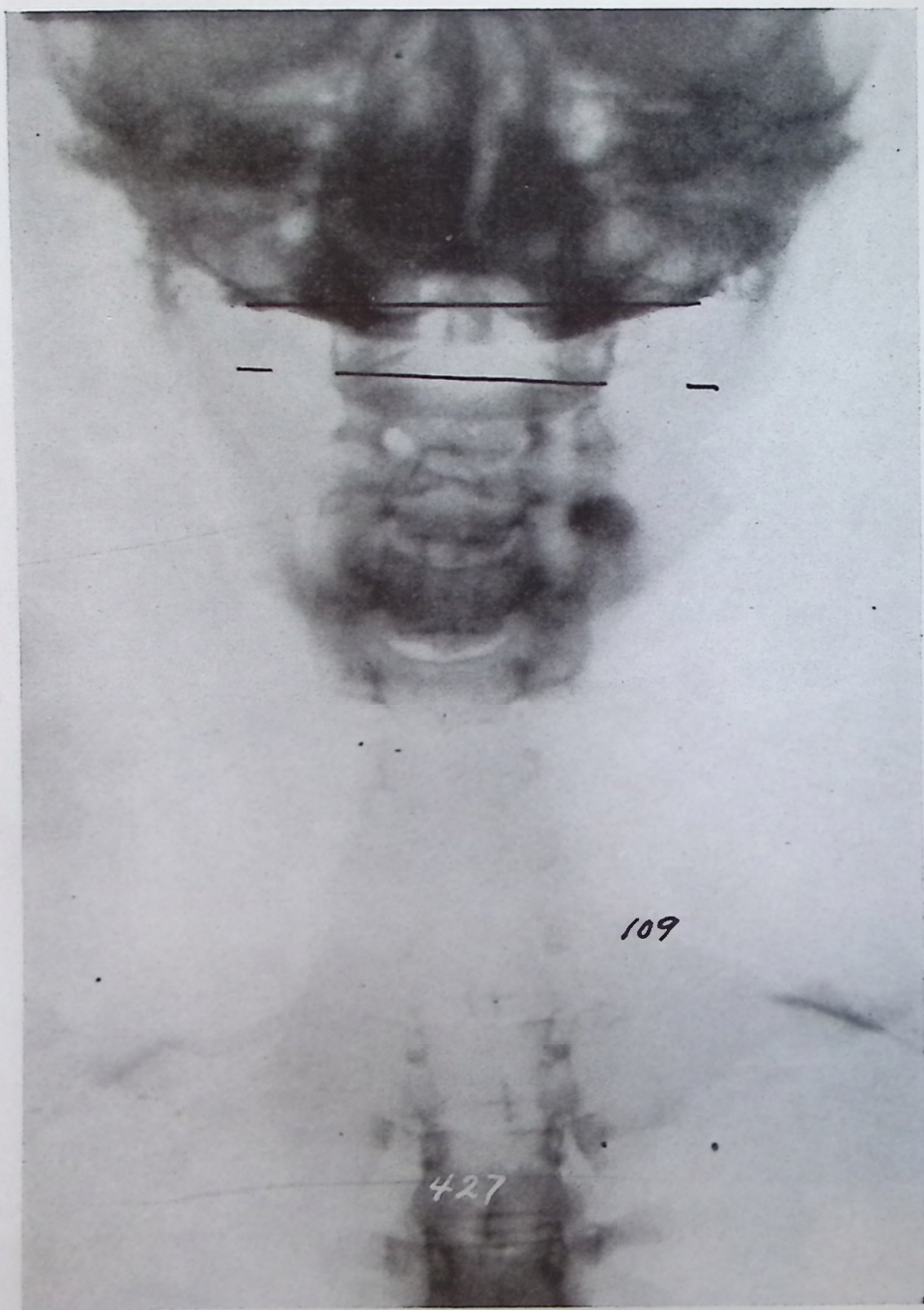


Illustration No. 427

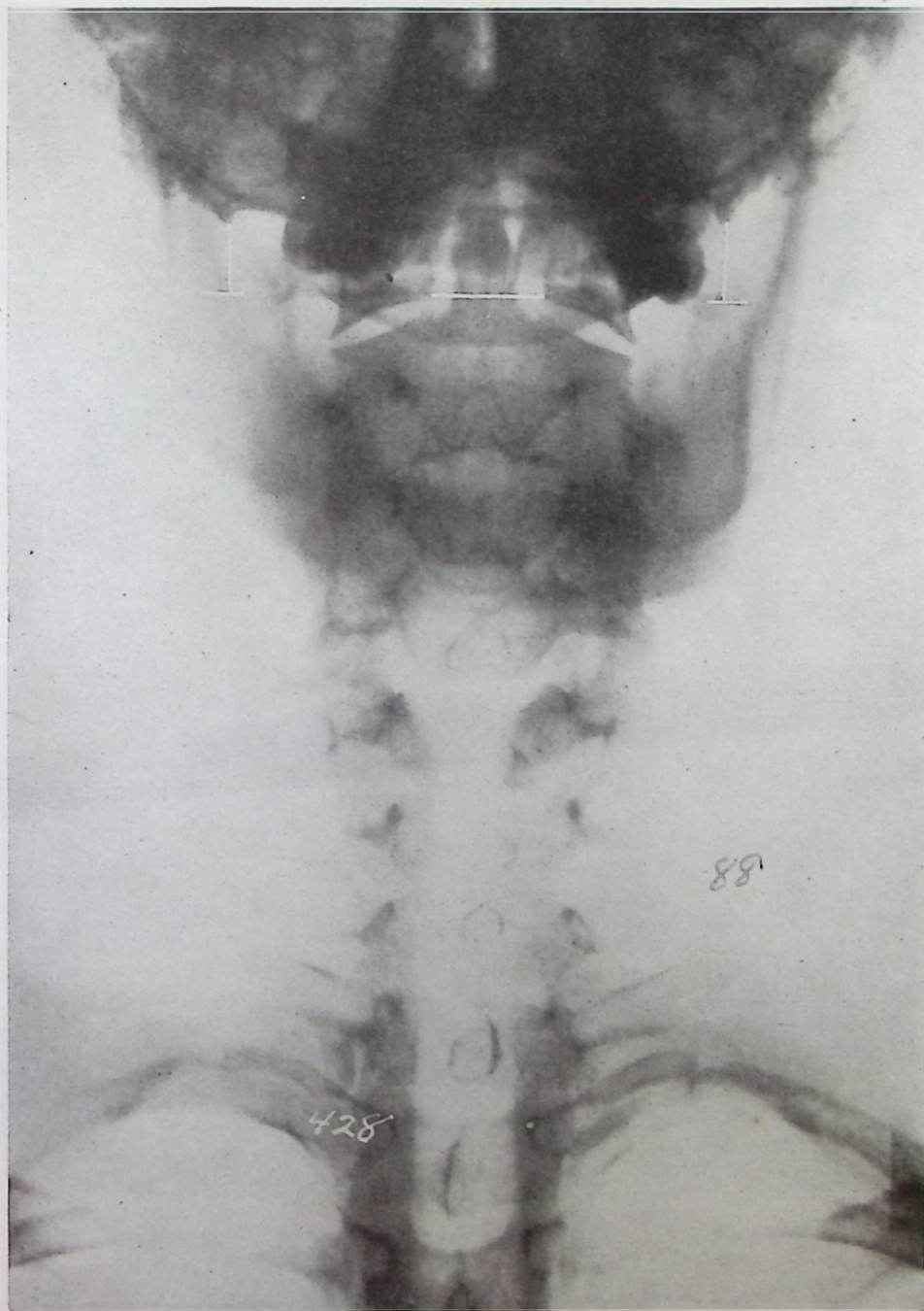


Illustration No. 428



Illustration No. 429

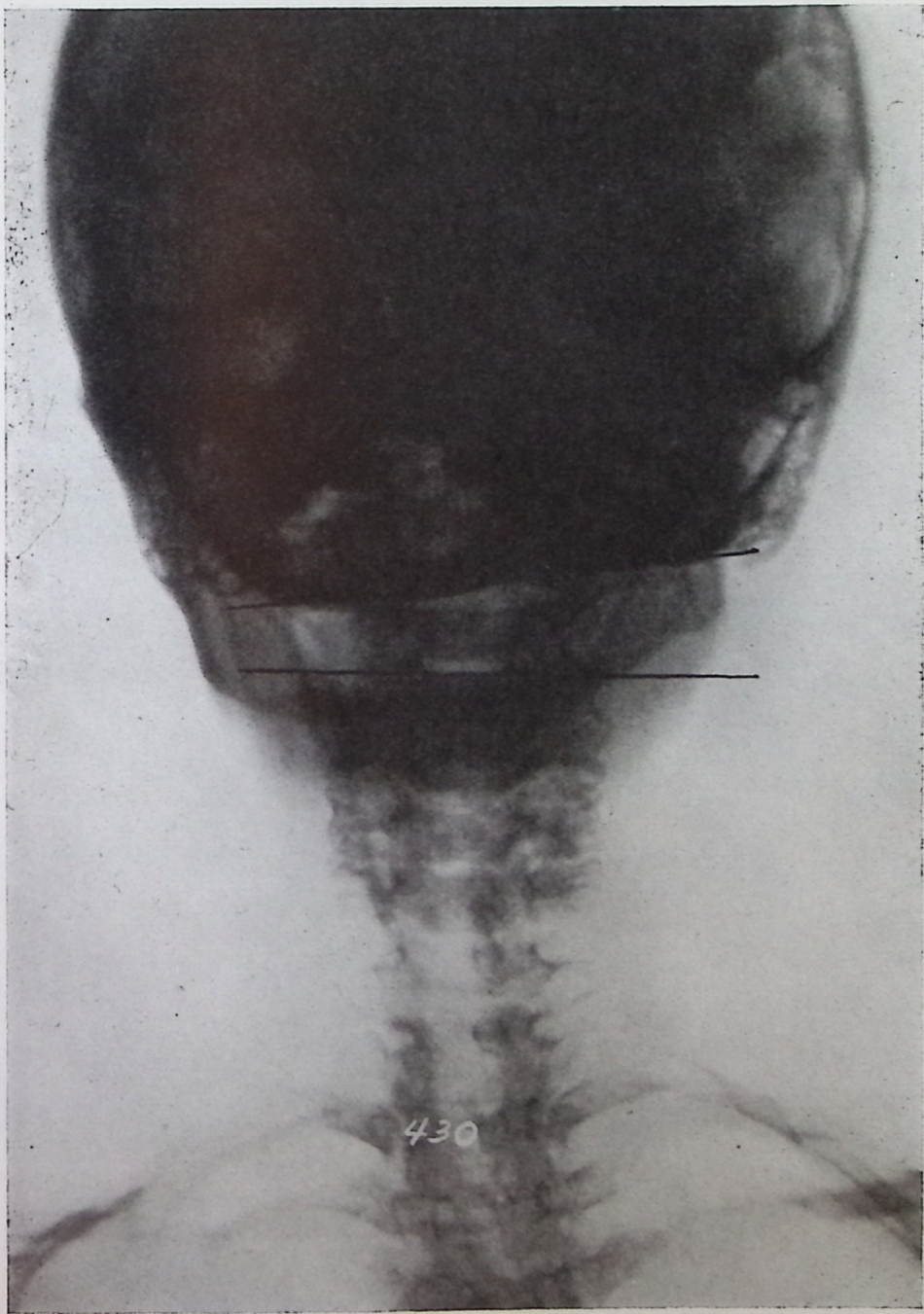


Illustration No. 430

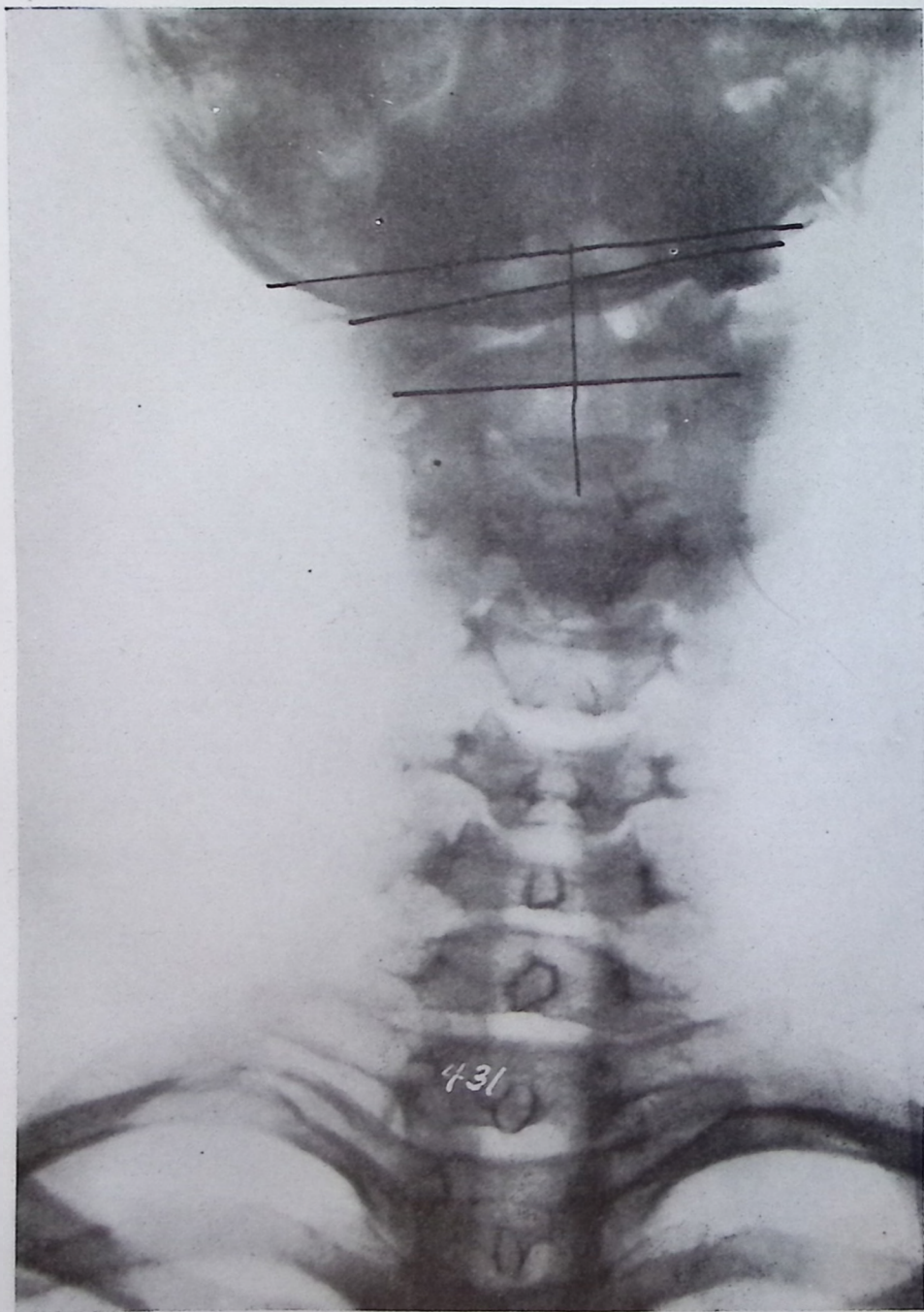


Illustration No. 431

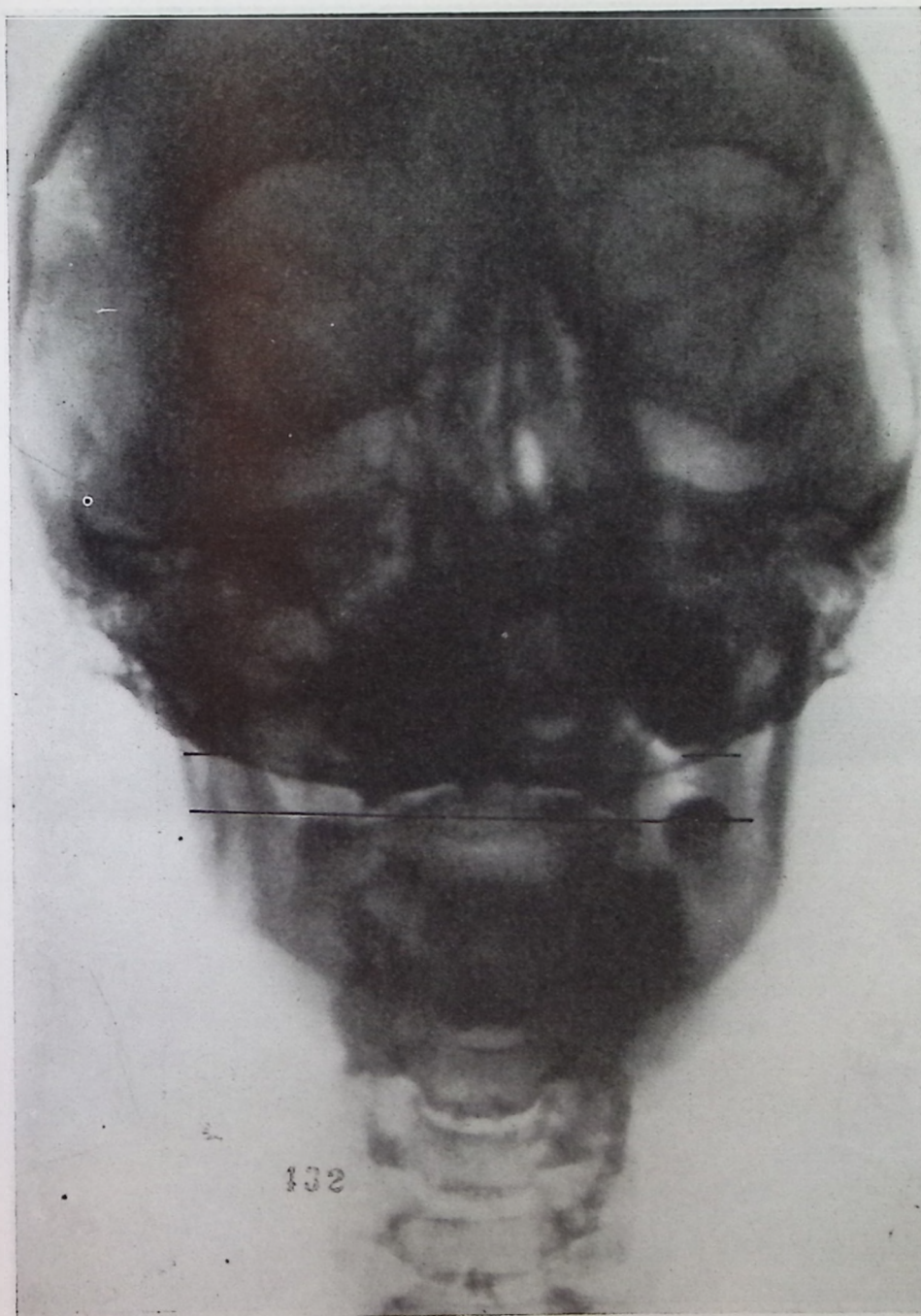


Illustration No. 432

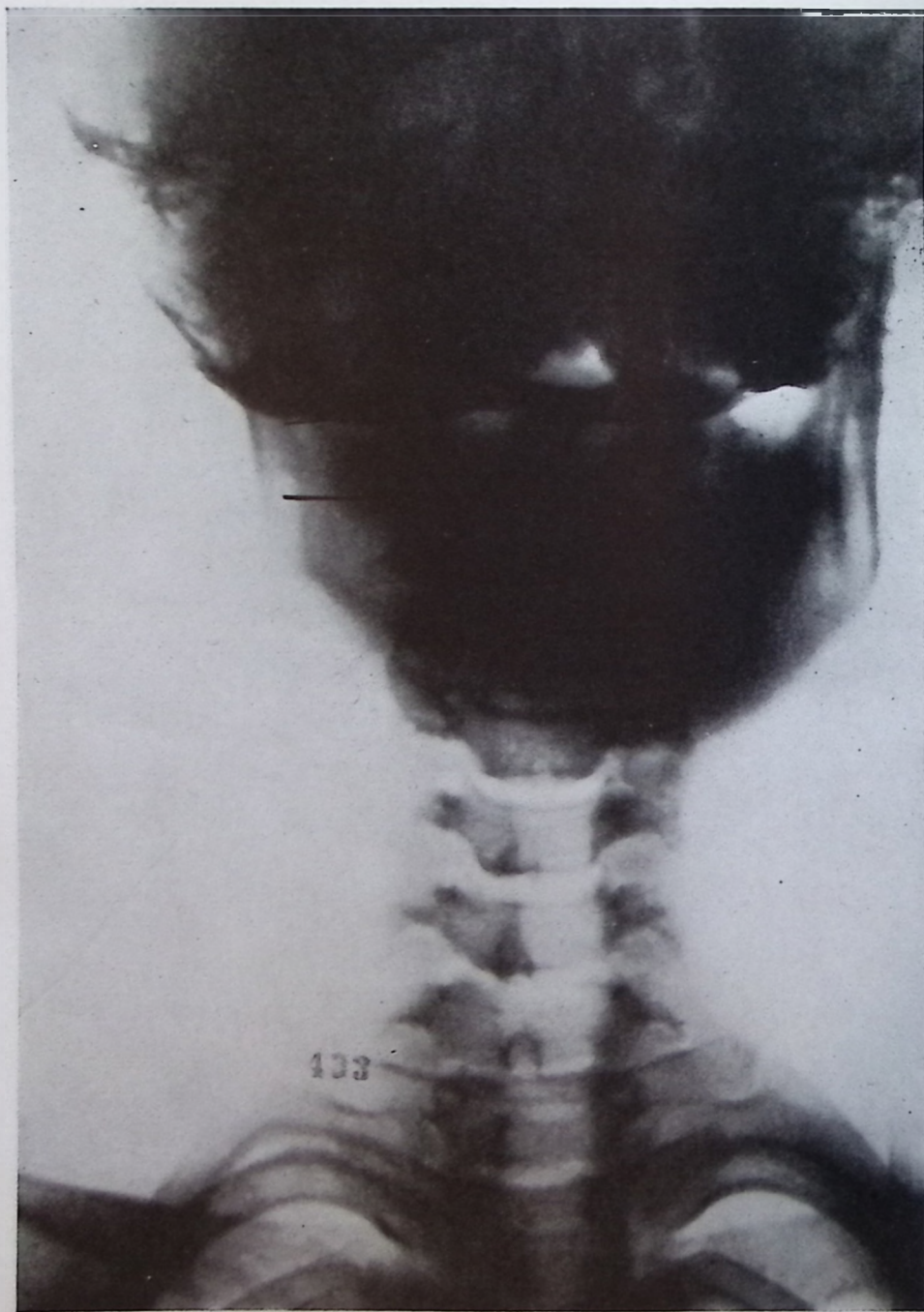


Illustration No. 433

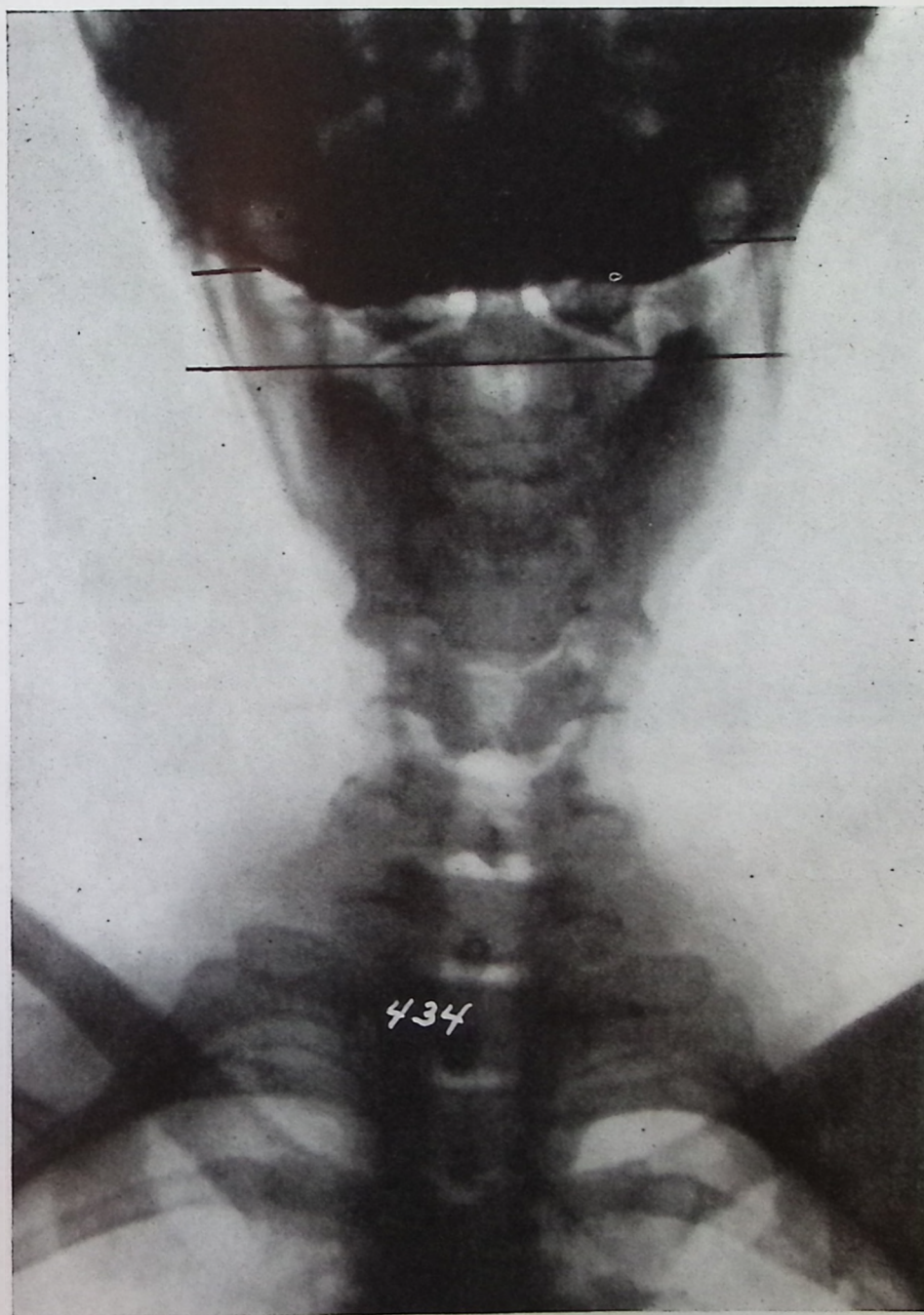


Illustration No. 434

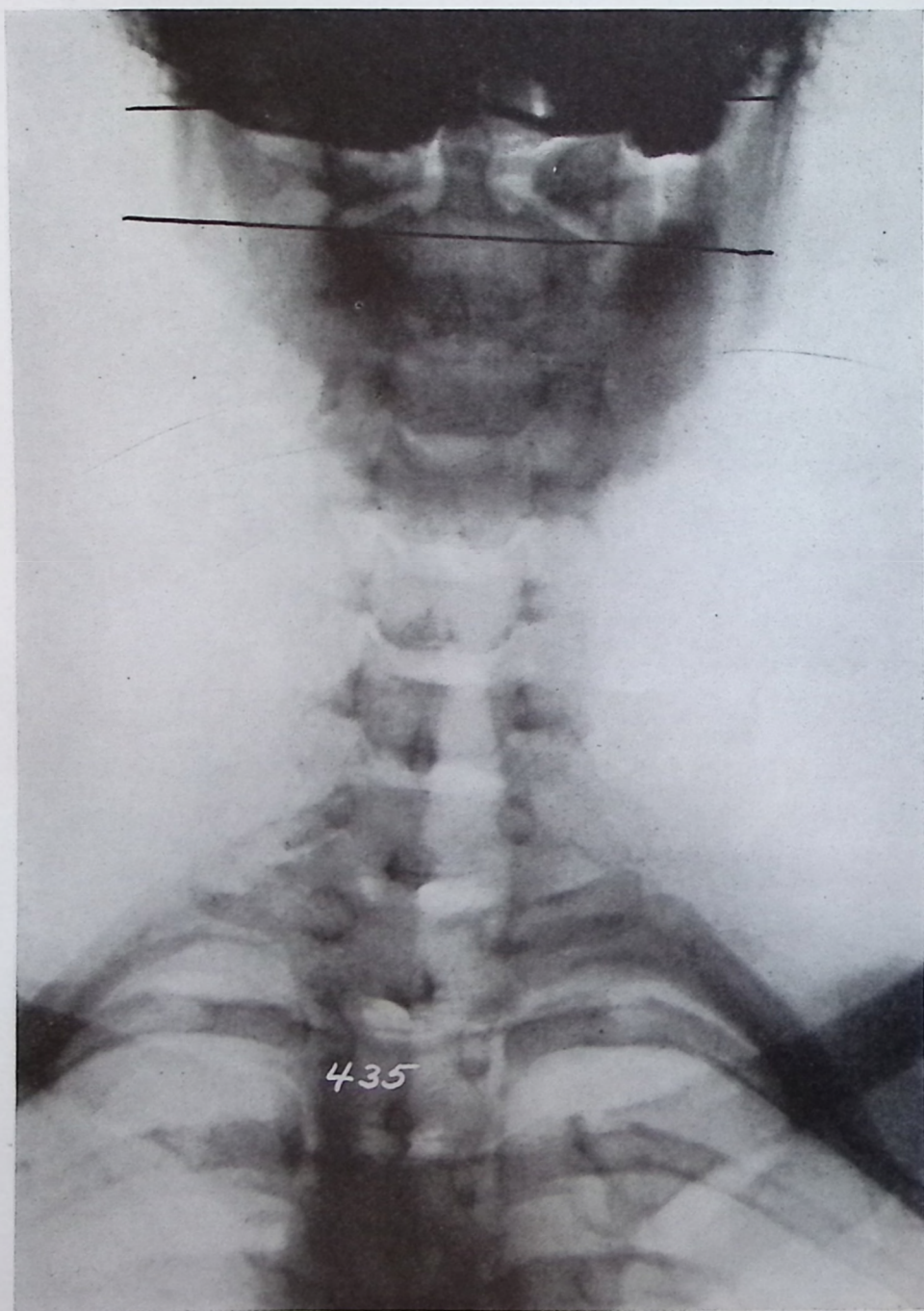


Illustration No. 435

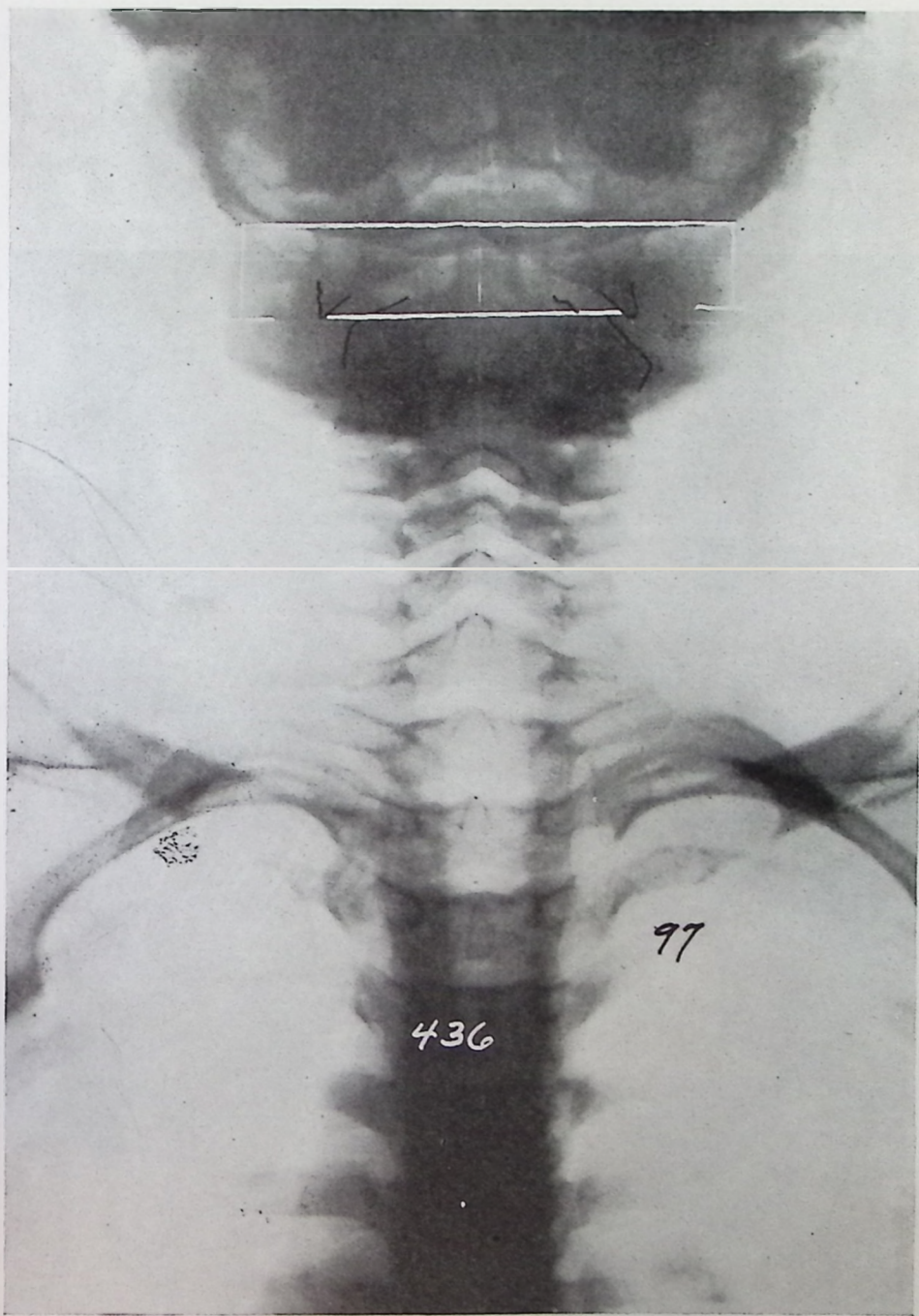


Illustration No. 436

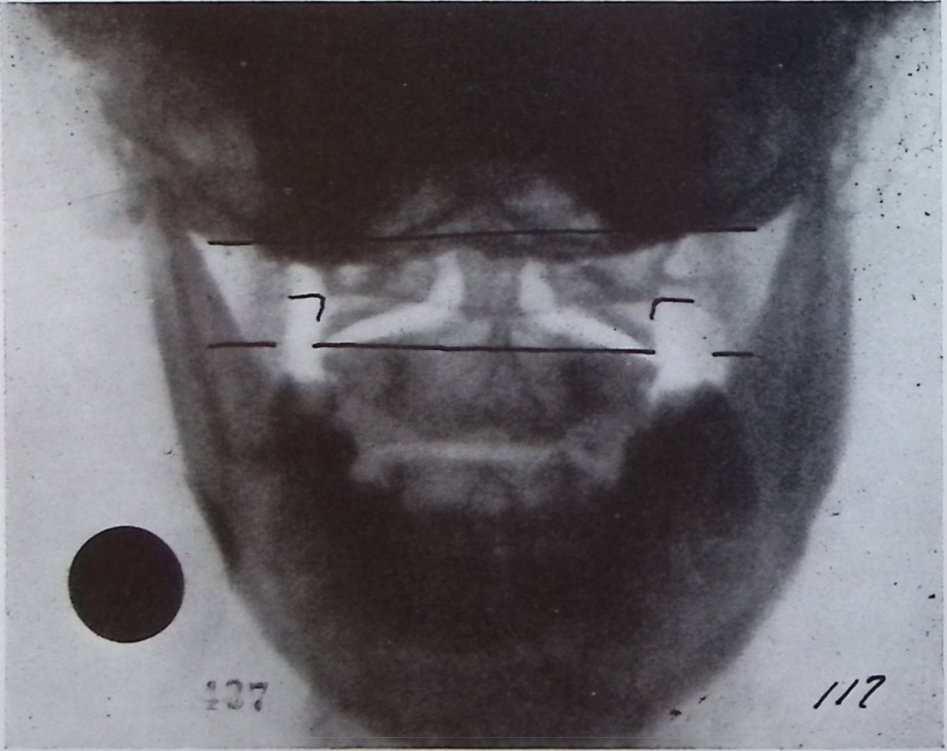


Illustration No. 437

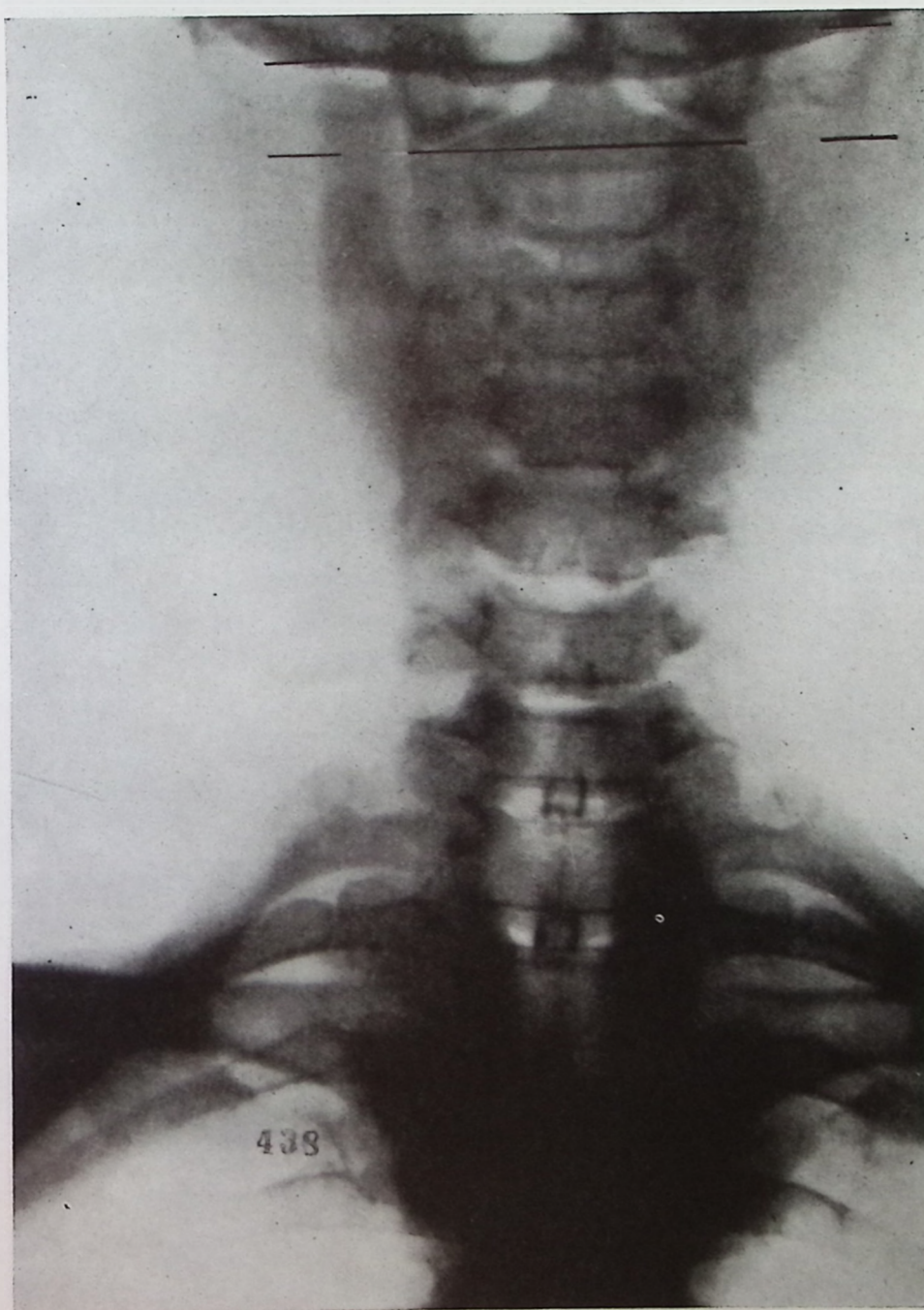


Illustration No. 438

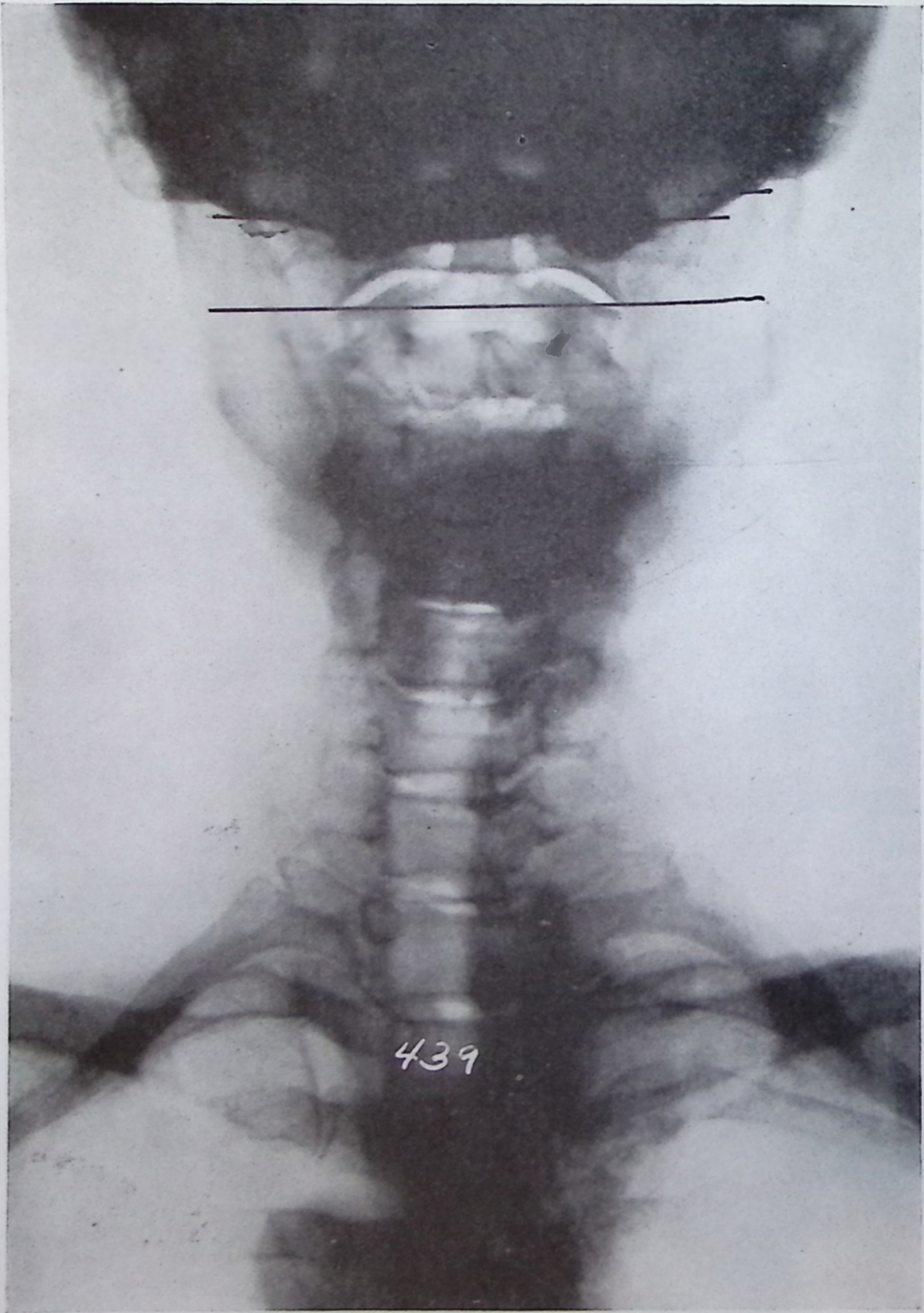


Illustration No. 439

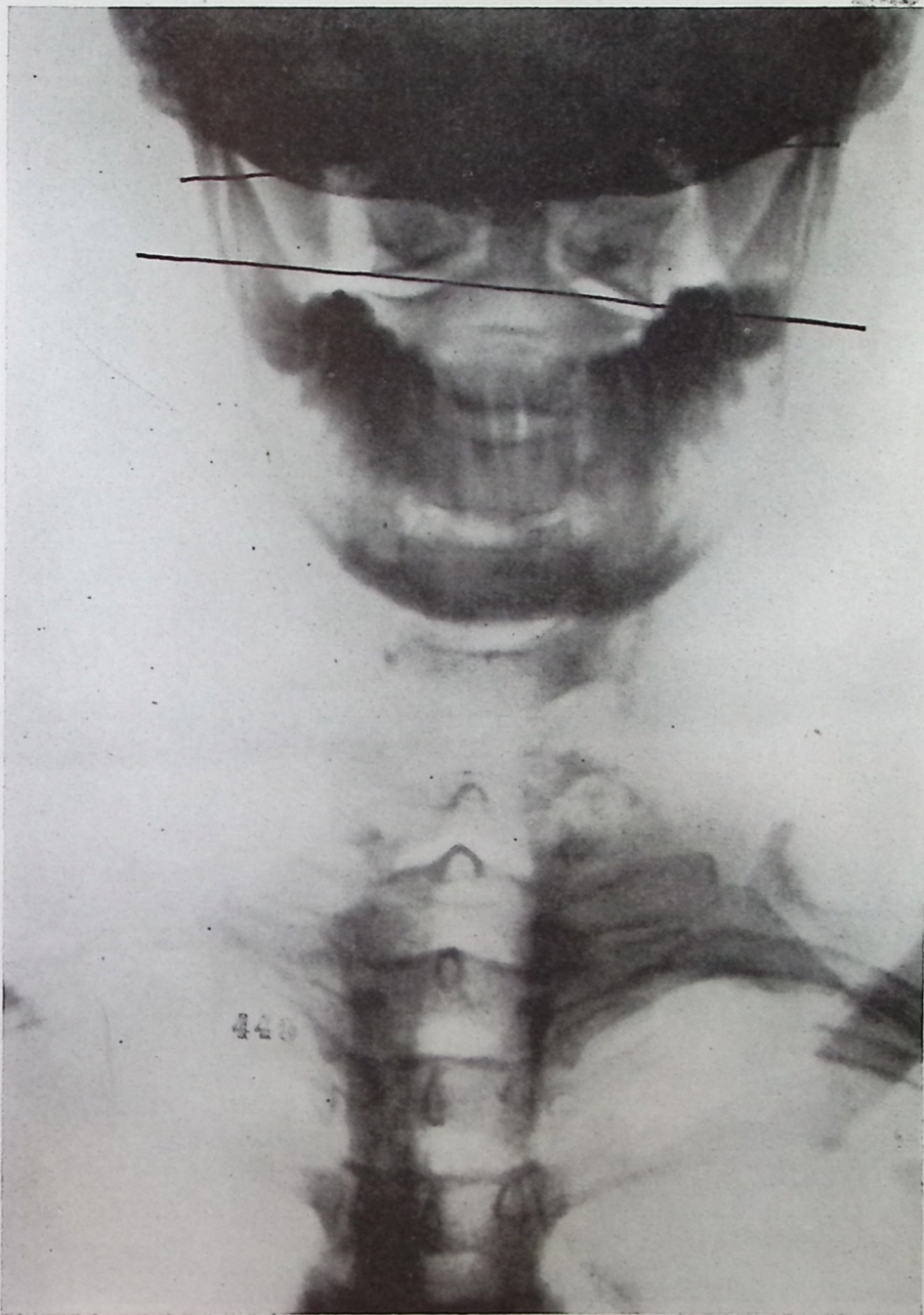


Illustration No. 440

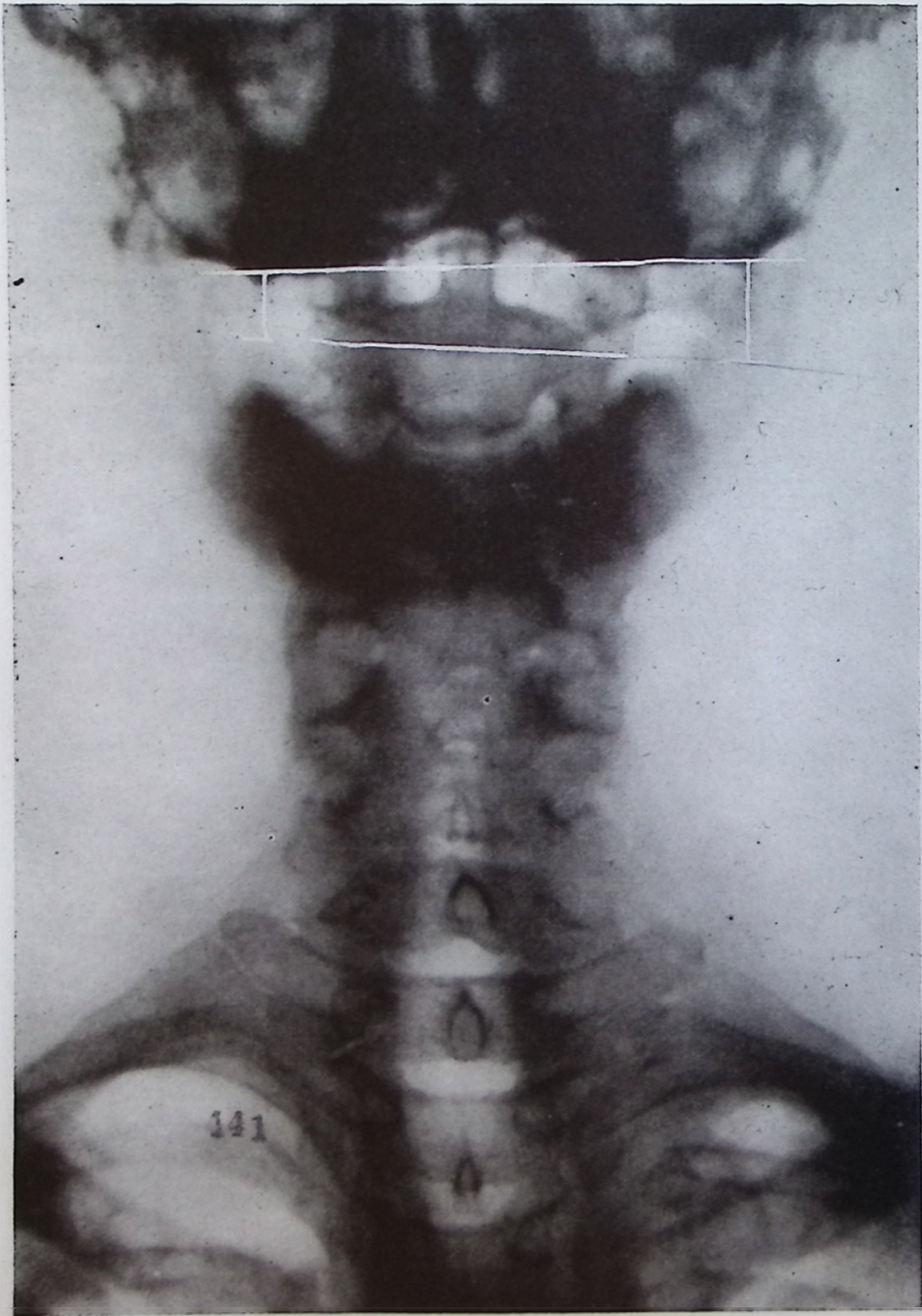


Illustration No. 441

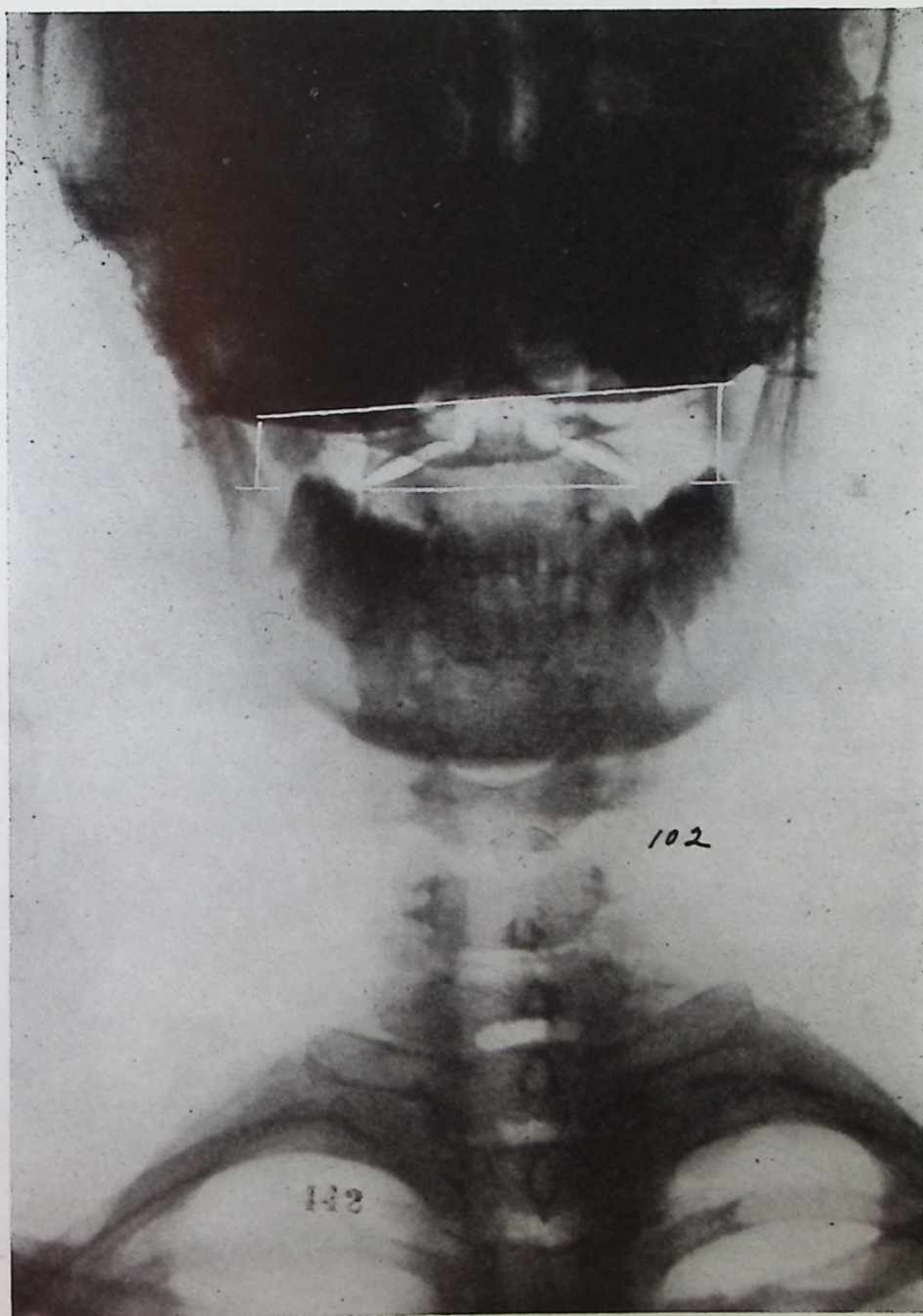


Illustration No. 442

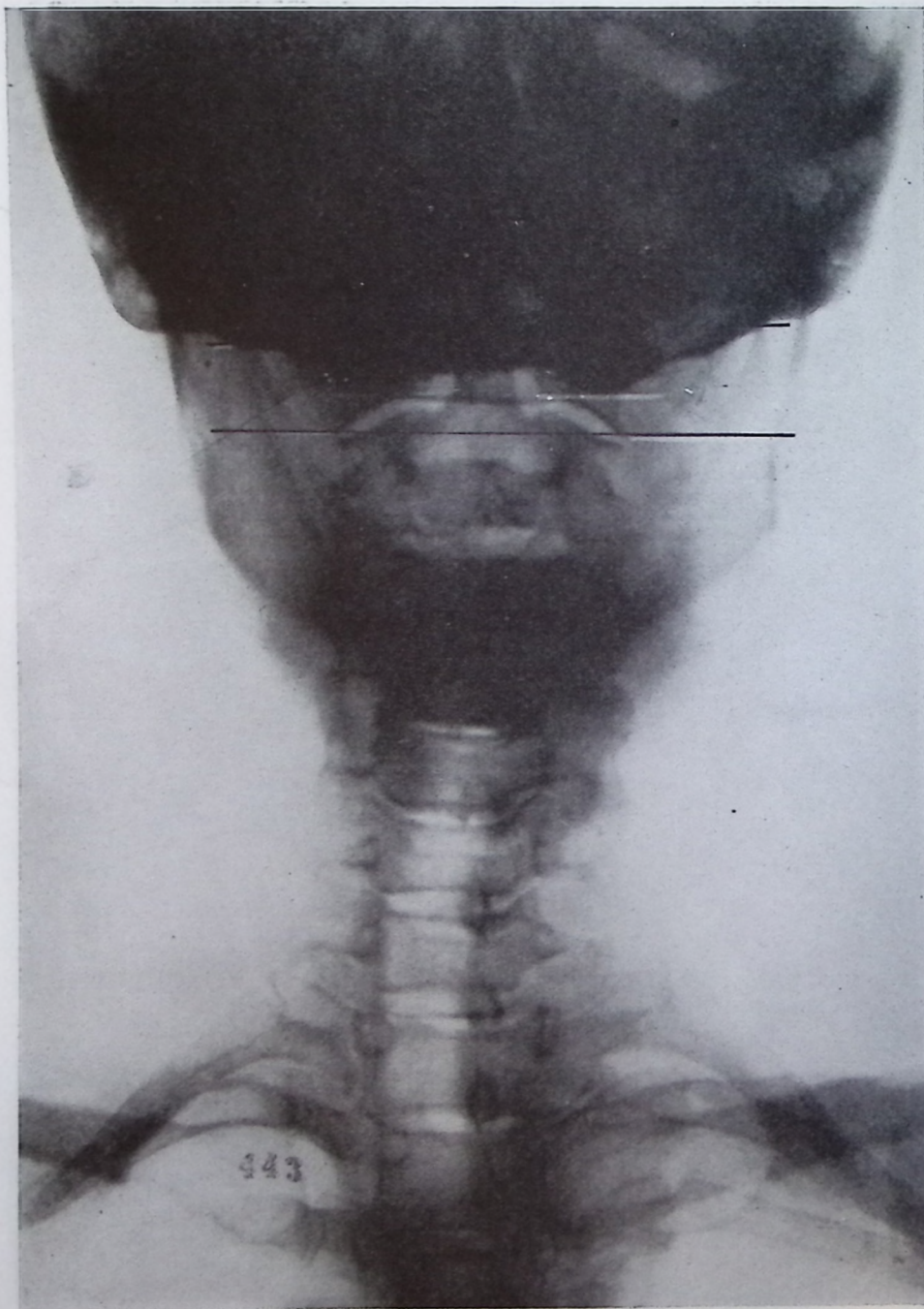


Illustration No. 443

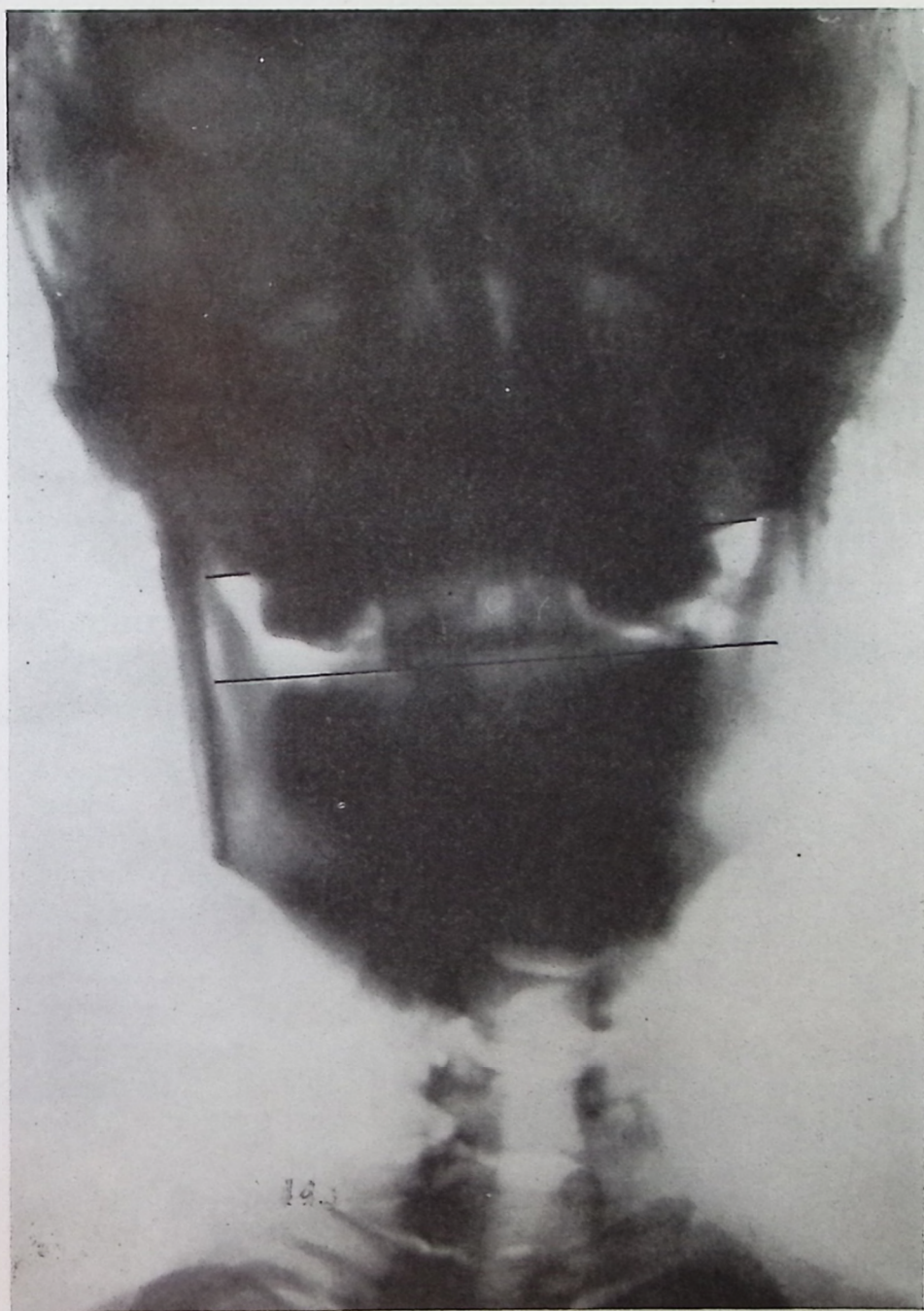


Illustration No. 444

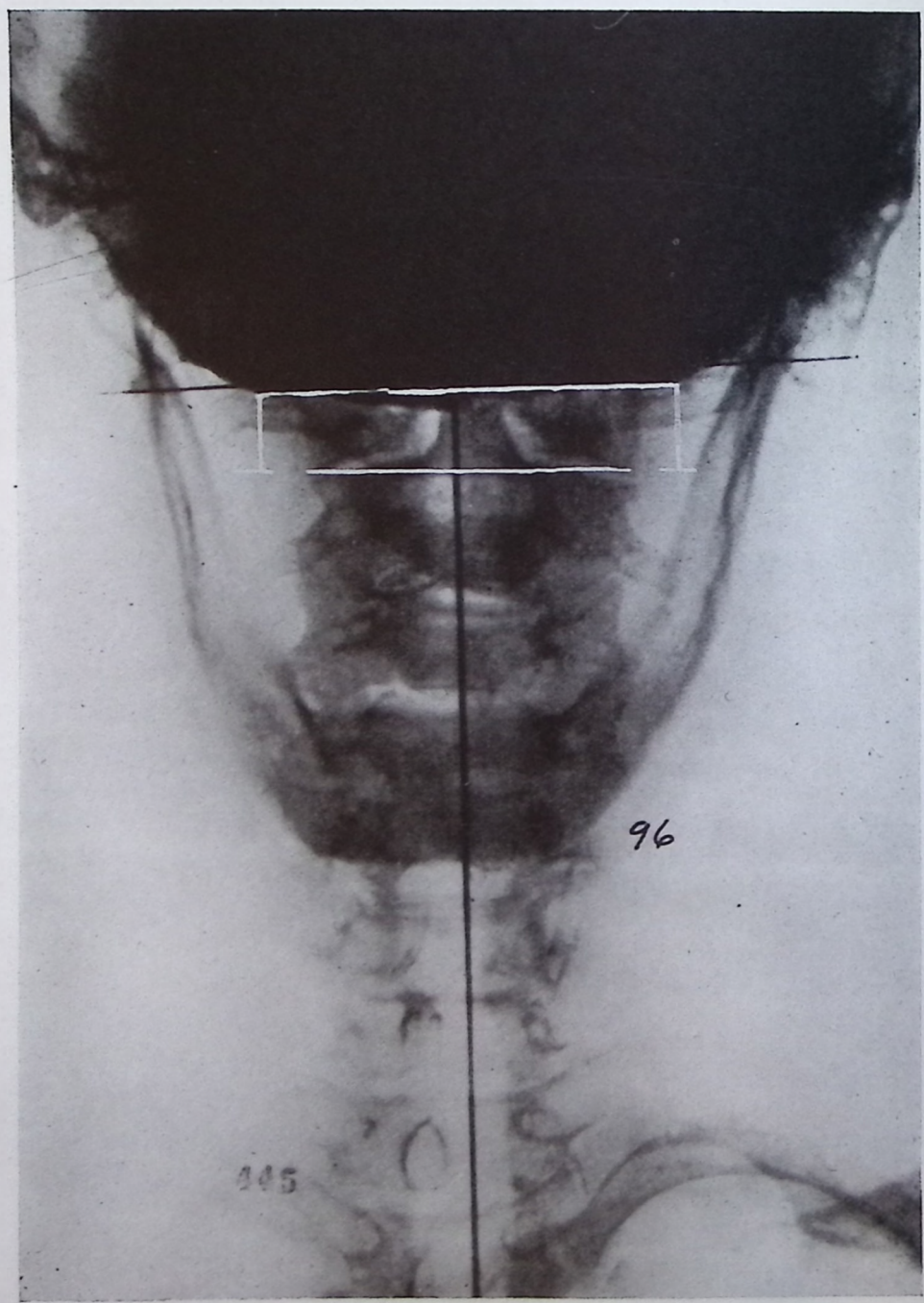


Illustration No. 445

CHAPTER XLI

UNUSUAL CASES

This book is the first edition on this subject. Only a limited number of copies are printed. This matter is being held in type subject to a subsequent edition, enlarged, as ideas and half-tones justify. We shall appreciate it if any of our chiropractors having unusual superior cervical conditions will send us the ORIGINAL FILMS that we might have prints made from same and use in future editions. Please give history of case and nature of accident if such.

Illustration 446, mate to 447. A-P view. Fracture of odontoid process of axis. Atlas and axis both subluxated. Atlas is R. HI wedge-side-slip. Axis is PRI true.

Illustration 447, mate to 446. Lateral view. Picture shows dislocation of odontoid process superior and anterior and ankylosed to anterior inferior rim of magnum foramen. No history of adjustment given.

Illustration 448, mate to 449. A-P view. Atals L. LO wedge-side-slip. Lateral proves it ASL.

Illustration 449, mate to 448. Lateral view. Shows atlas anterior arch almost a dislocation over superior rim of odontoid process.

Illustration 450, mate to 451. A-P view. Shows fracture of odontoid process with practically no dislocation except it is superior from its base. Atlas is AIL wedge-side-slip.

Illustration 451, mate to 450. Lateral view. Shows axis very much posterior into neural canal. Skull and head have remained together in position.

Illustration 452. Marked angular cervical kyphosis. Atlas AI.

Illustration 453, mate to 454. A-P view. Shows no odontoid process. Prenatal. Just a nub exists. Atlas L. HI wedge-side-slip.

Illustration 454, mate to 453. Lateral view. Atlas anterior of occiput and axis. Position of atlas determined because of no odontoid process.

Illustration 455. Note location of atlas. Posterior arch crowding occiput. Axis odontoid very posterior into neural canal.

Illustration 456, mate to 457. Atlas R. LO. Listing AIR.

Illustration 457, mate to 456. Note location of axis odontoid process in relation to neural canal.

Illustration 458. Note location of odontoid process. Atlas crowded inferiorly on axis.

Illustration 459. Atlas without posterior arch. Ununited.

Illustration 460, mate to 461. Undoubtedly fracture with compression against occiput. Atlas not observable on A-P view.

Illustration 461, mate to 460. Lateral view. Atlas crowded close to occiput. Axis and 3rd cervical ankylosed.

Illustration 462. Lateral view. Note location of axis odontoid process into neural canal.

Illustration 463. Lateral view. Note location of axis odontoid process into neural canal.

Illustrations 464 to 467. Illustration 464 shows fractured odontoid process with some dislocation. A-P view.

Illustration 465. 30 days later after one adjustment on atlas. Compare with 464. Not quite so far dislocated.

Illustration 466. 60 days following taking case. 3 adjustments. Atlas only. United to base.

Illustration 467. 60 days following taking case. 3 adjustments. Atlas only. Odontoid united and healed.

Illustration 468. Atlas without posterior arch. Ununited. Bifid development. Mate to 469.

Illustration 469. Lateral view. Mate to 468. Atlas shows ununited posterior arch of atlas.

Illustration 470. A-P view only. Fractured odontoid process.



Illustration No. 446



Illustration No. 447

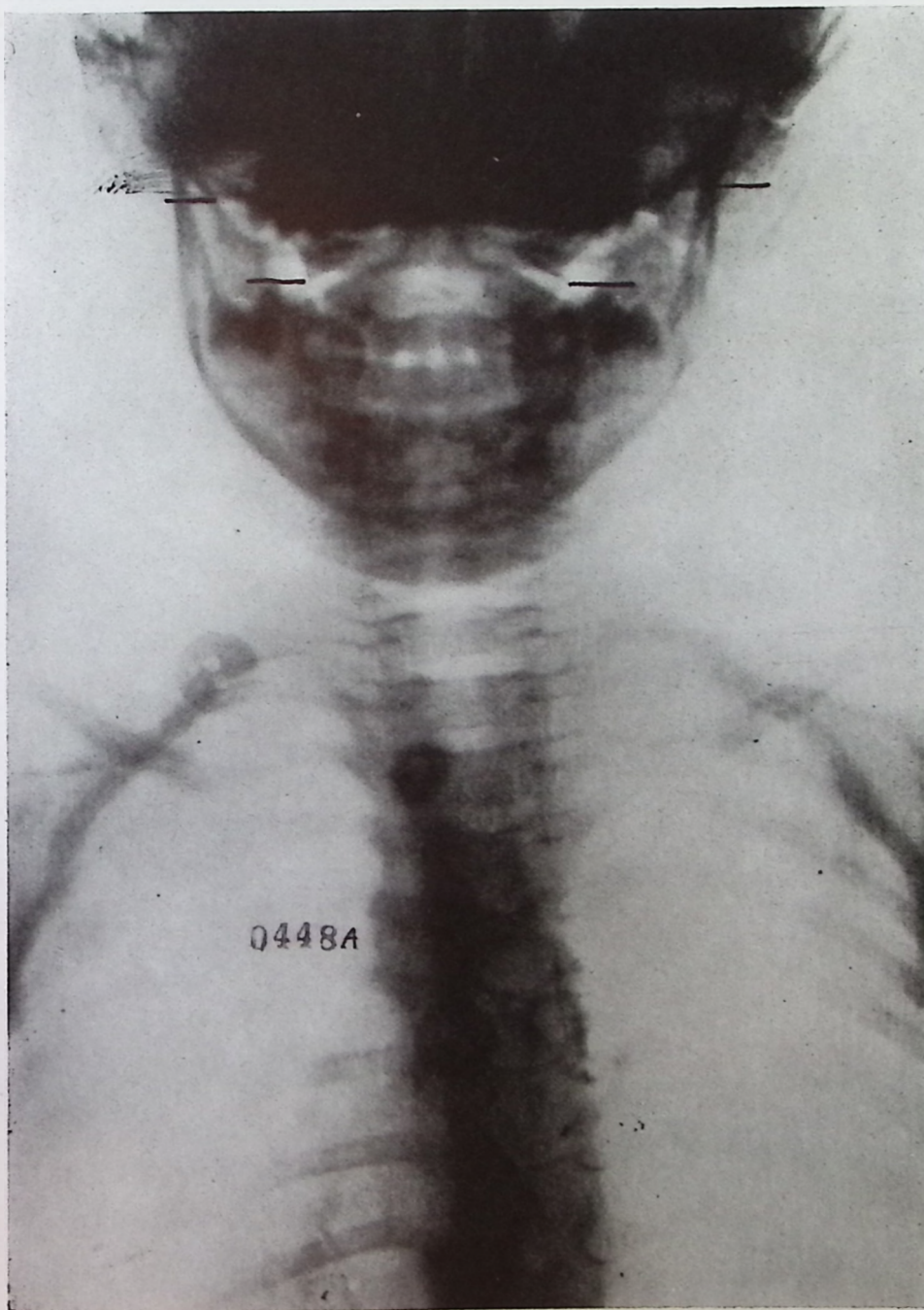


Illustration No. 448



Illustration No. 449

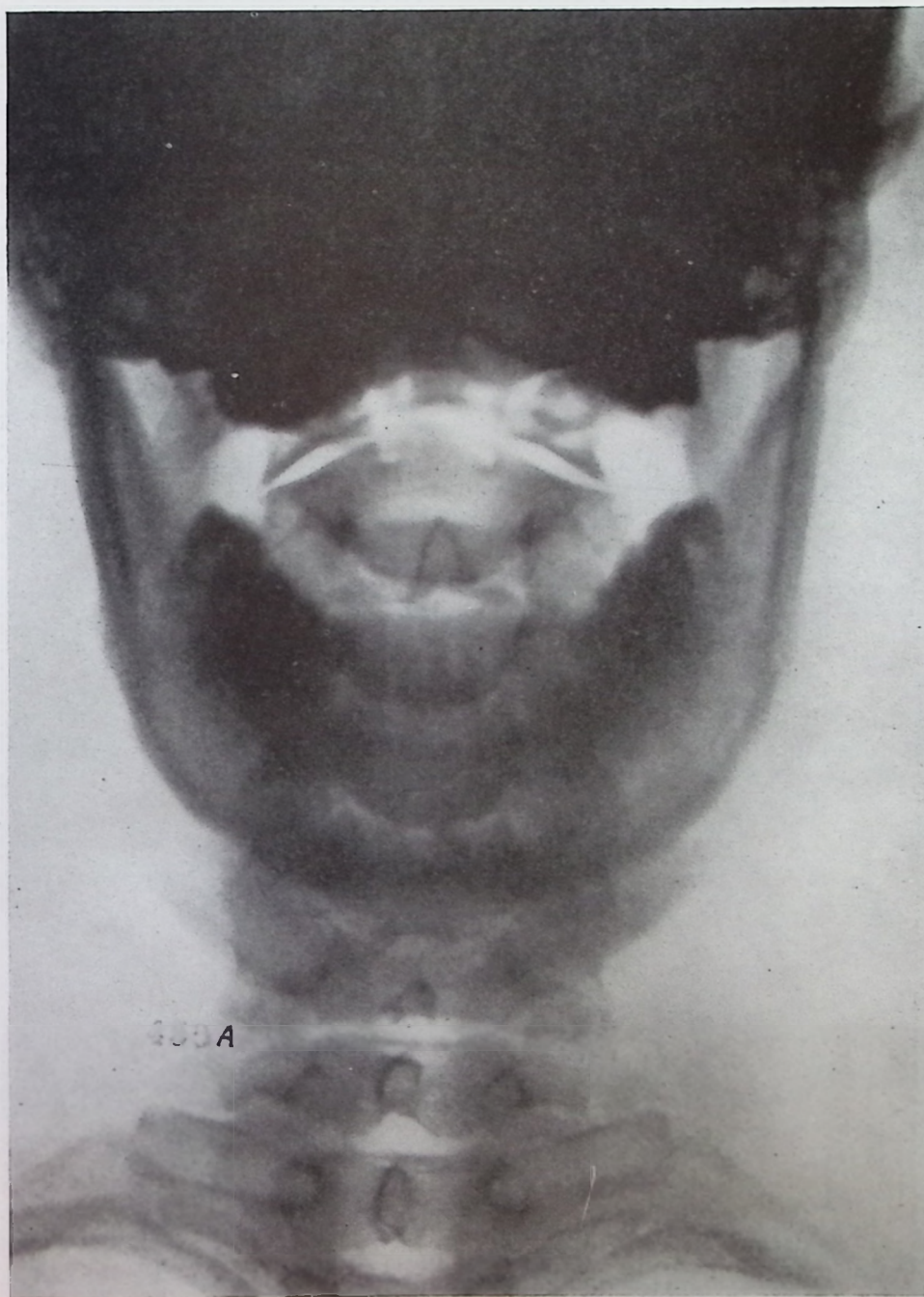


Illustration No. 450



Illustration No. 451



Illustration No. 452

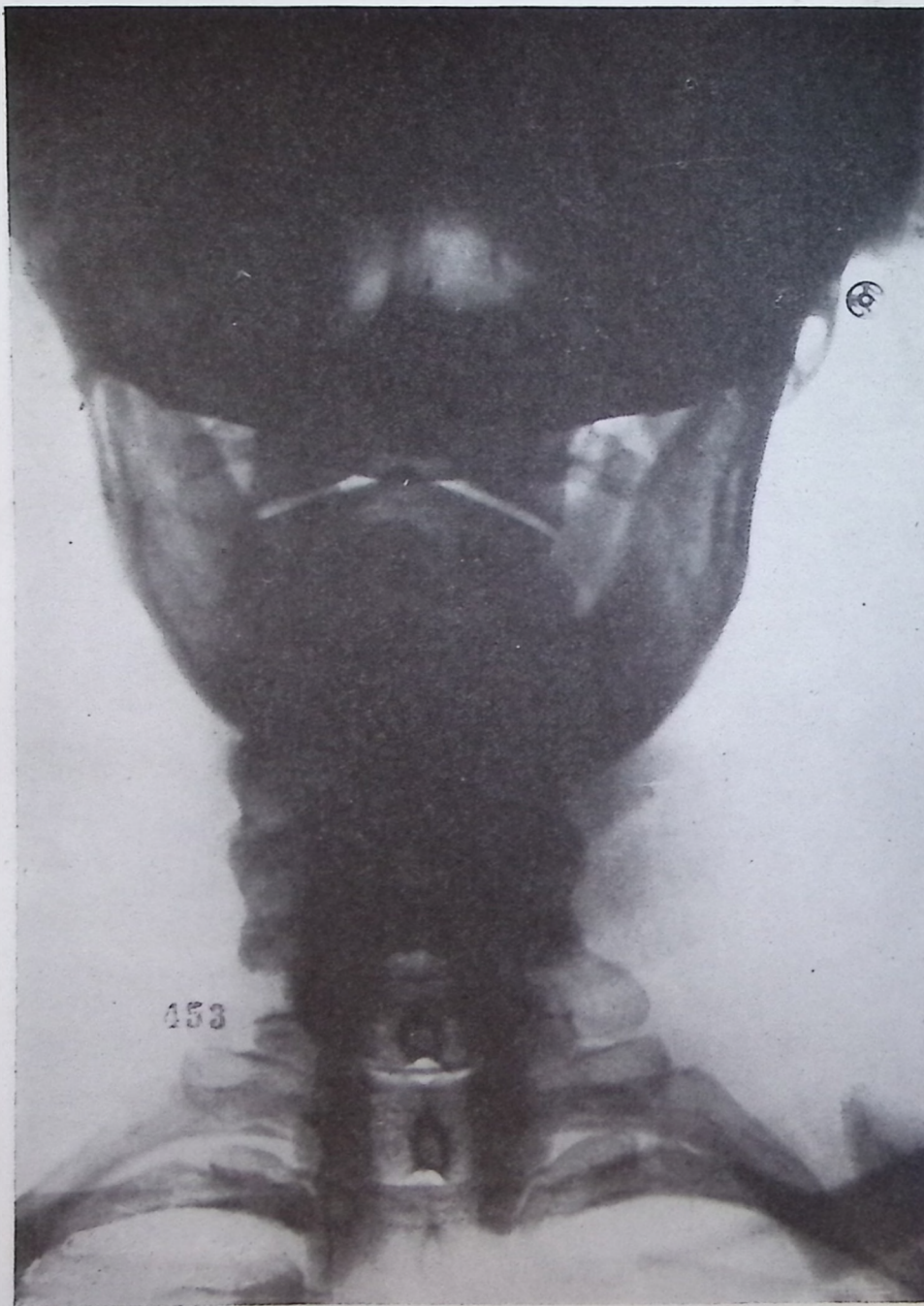


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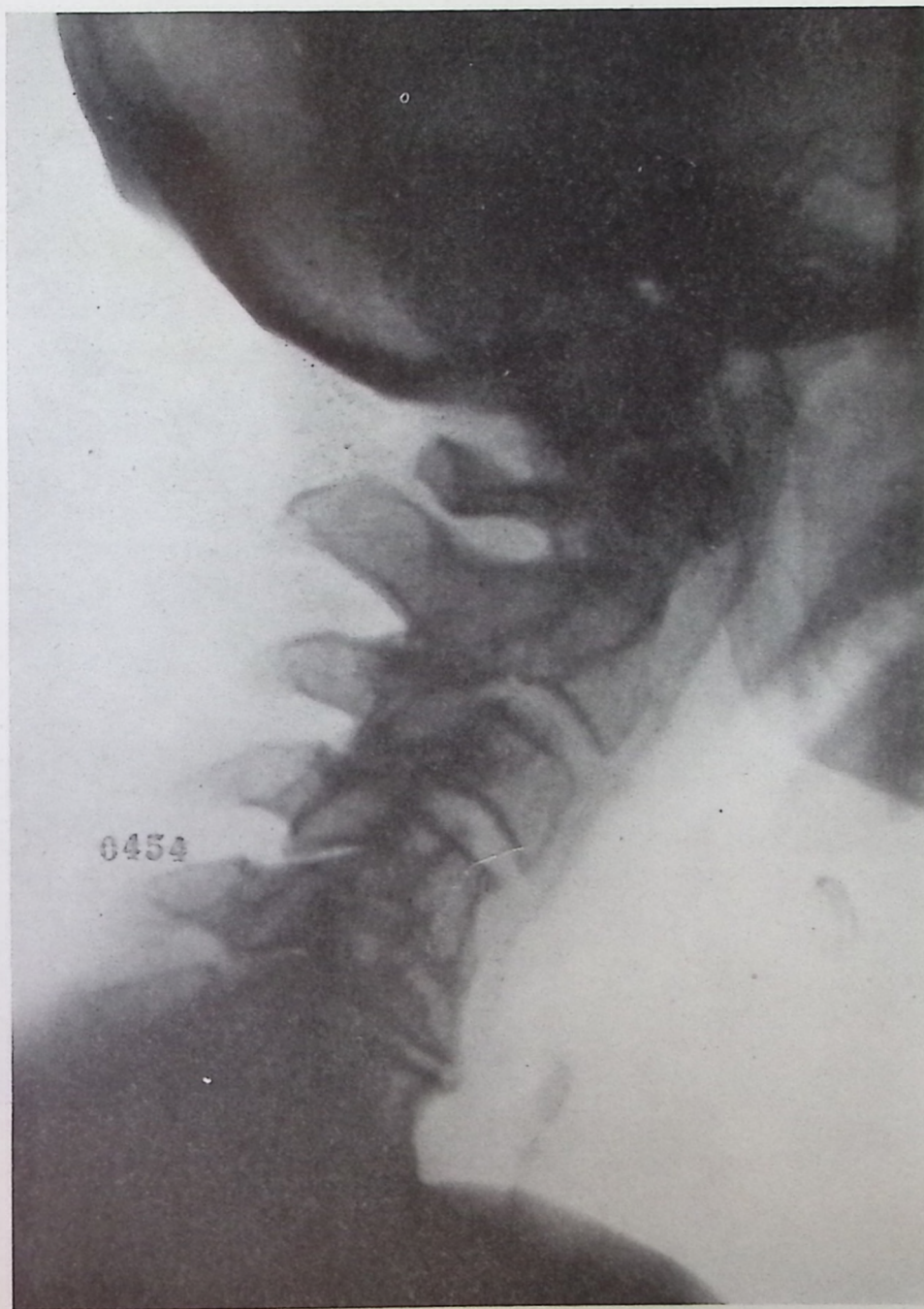


Illustration No. 454



Illustration No. 455



Illustration No. 456

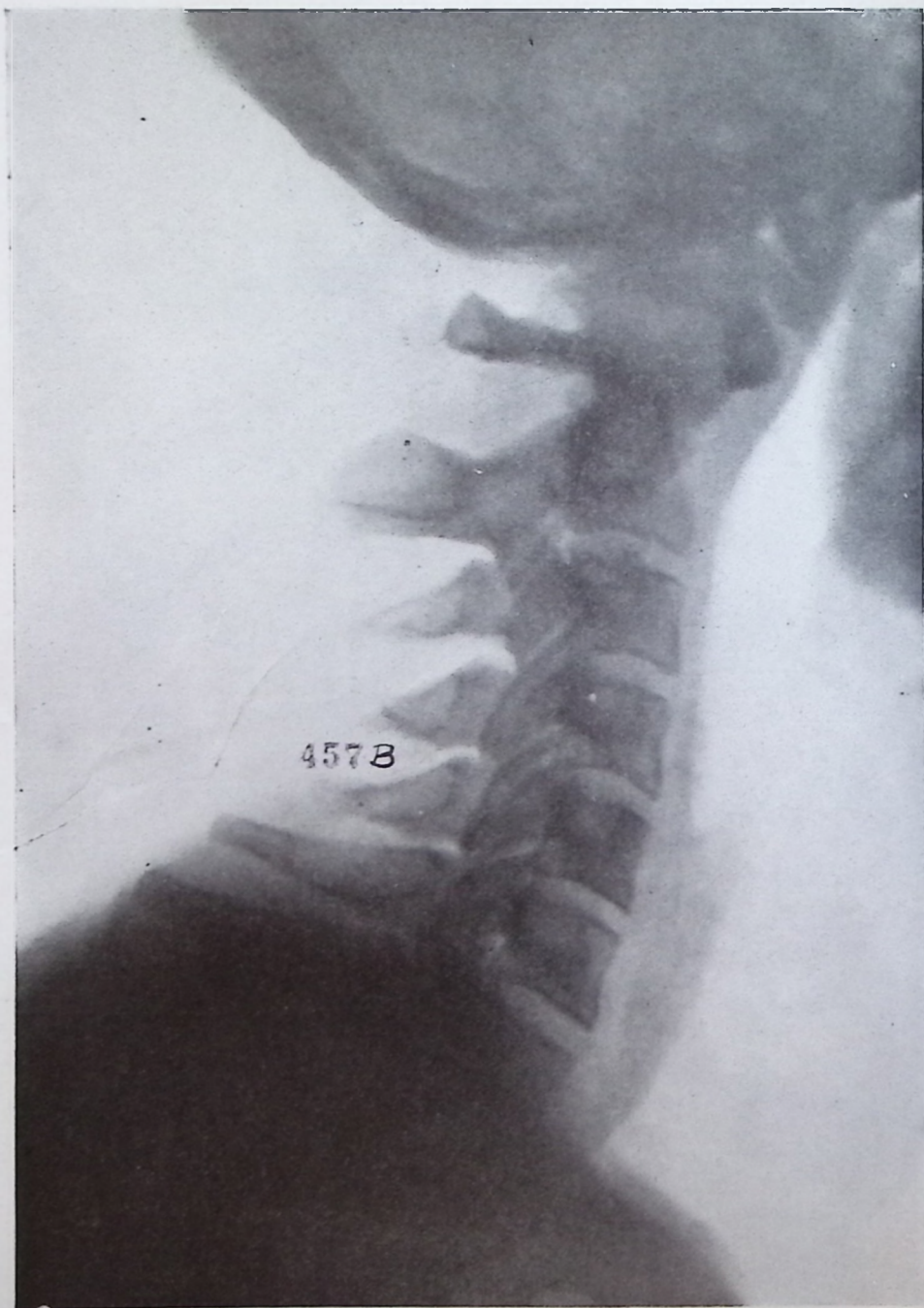


Illustration No. 457



Illustration No. 458



Illustration No. 459



Illustration No. 460



Illustration No. 461

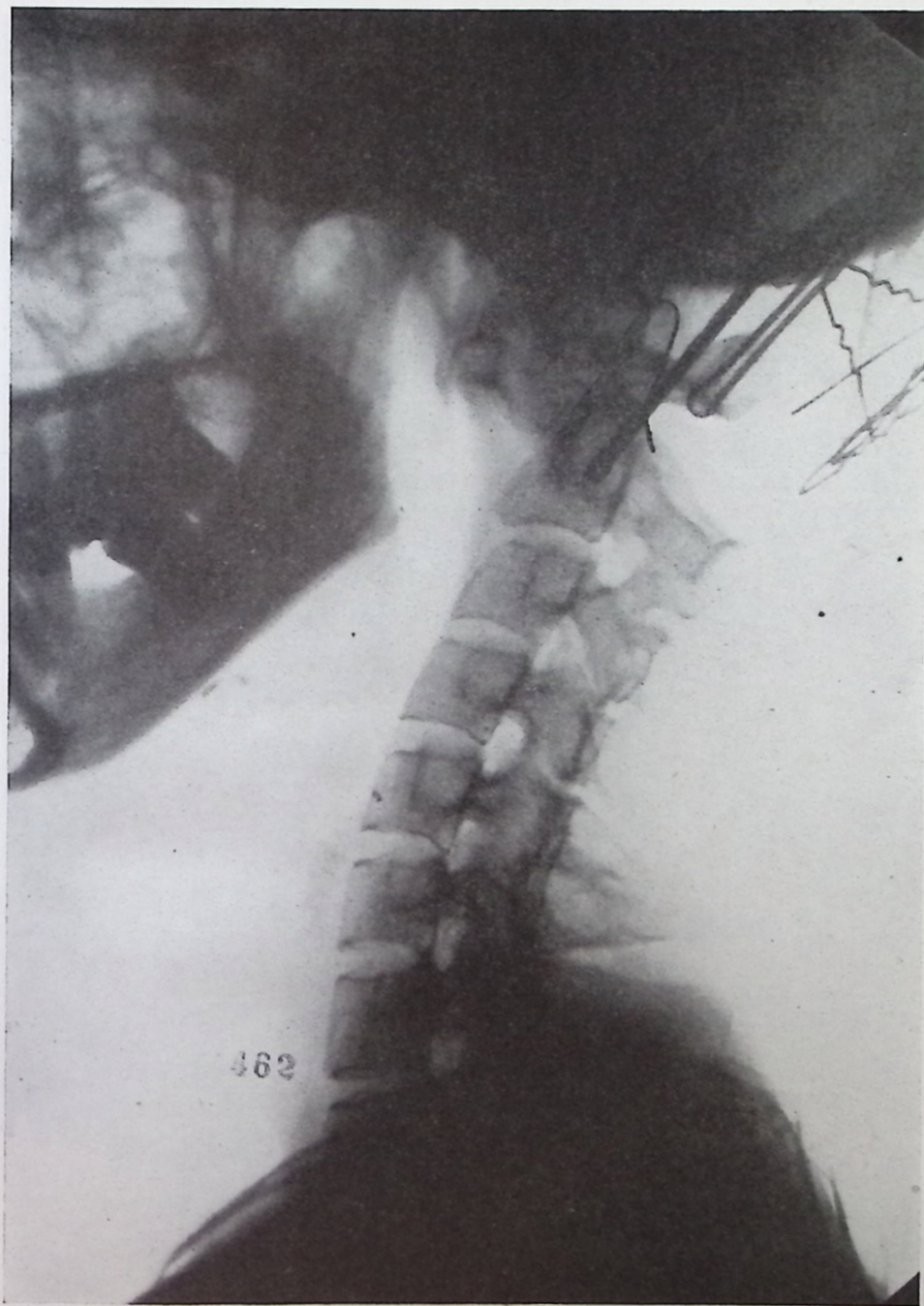


Illustration No. 462



Illustration No. 463



Illustration No. 464

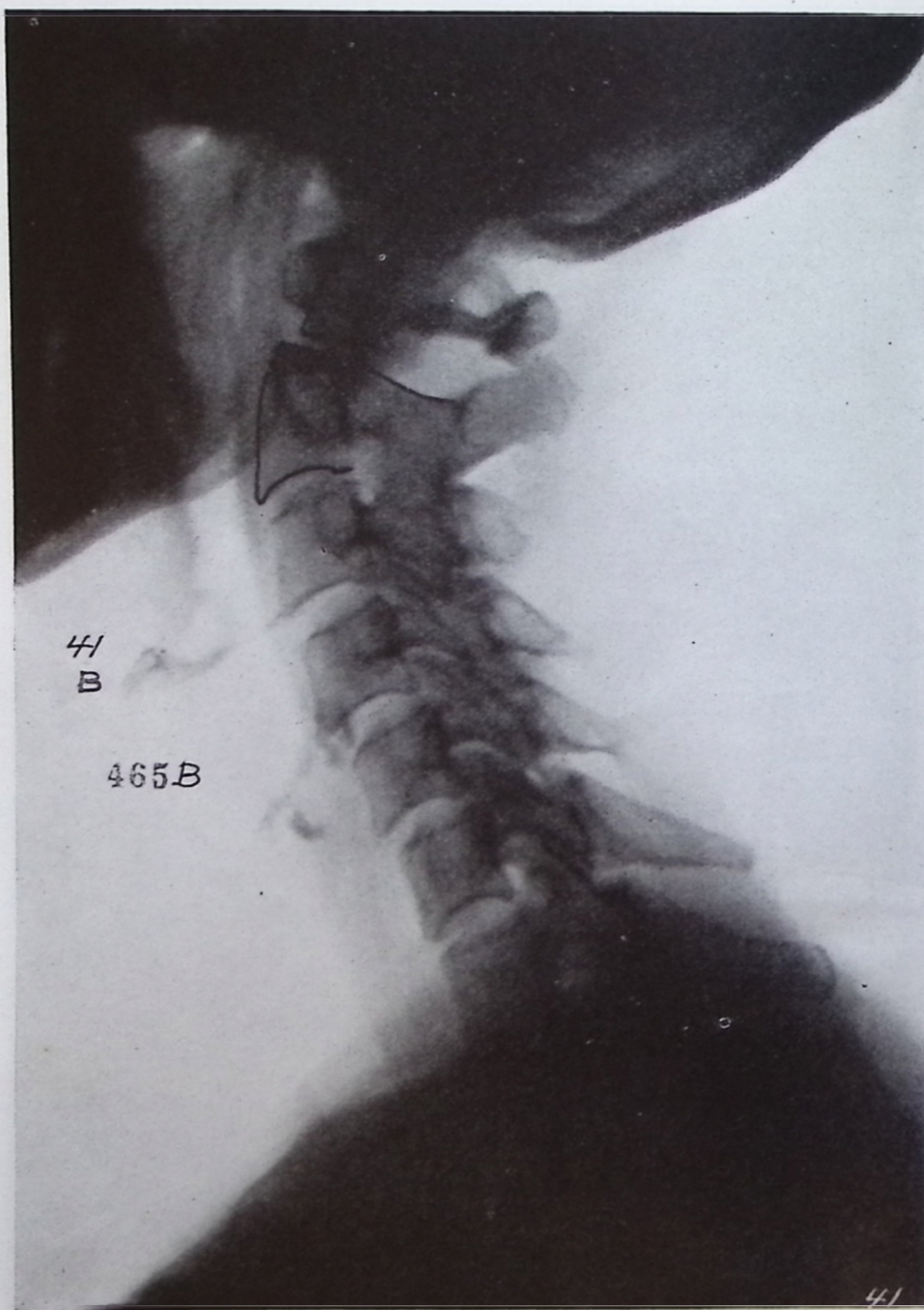


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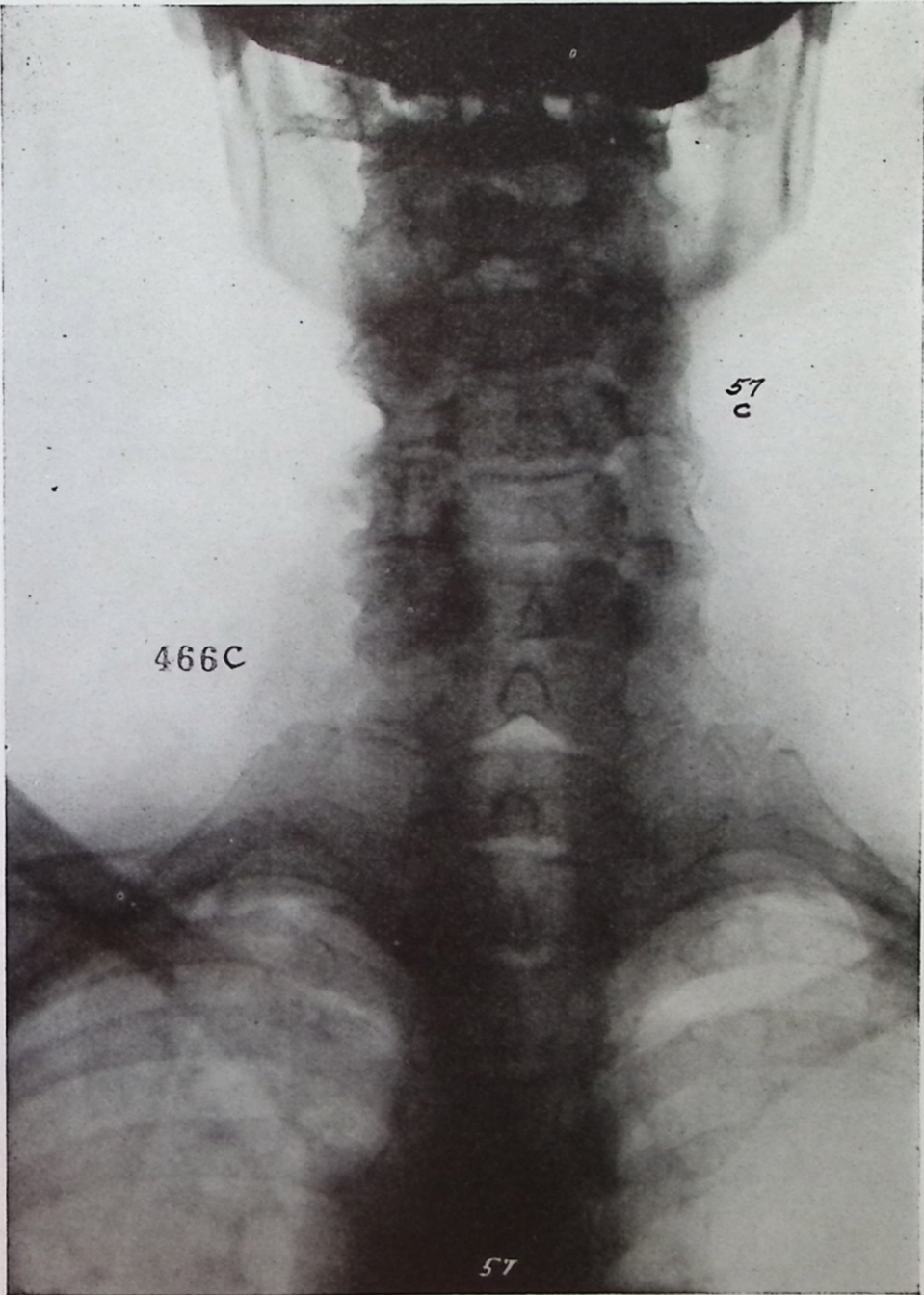


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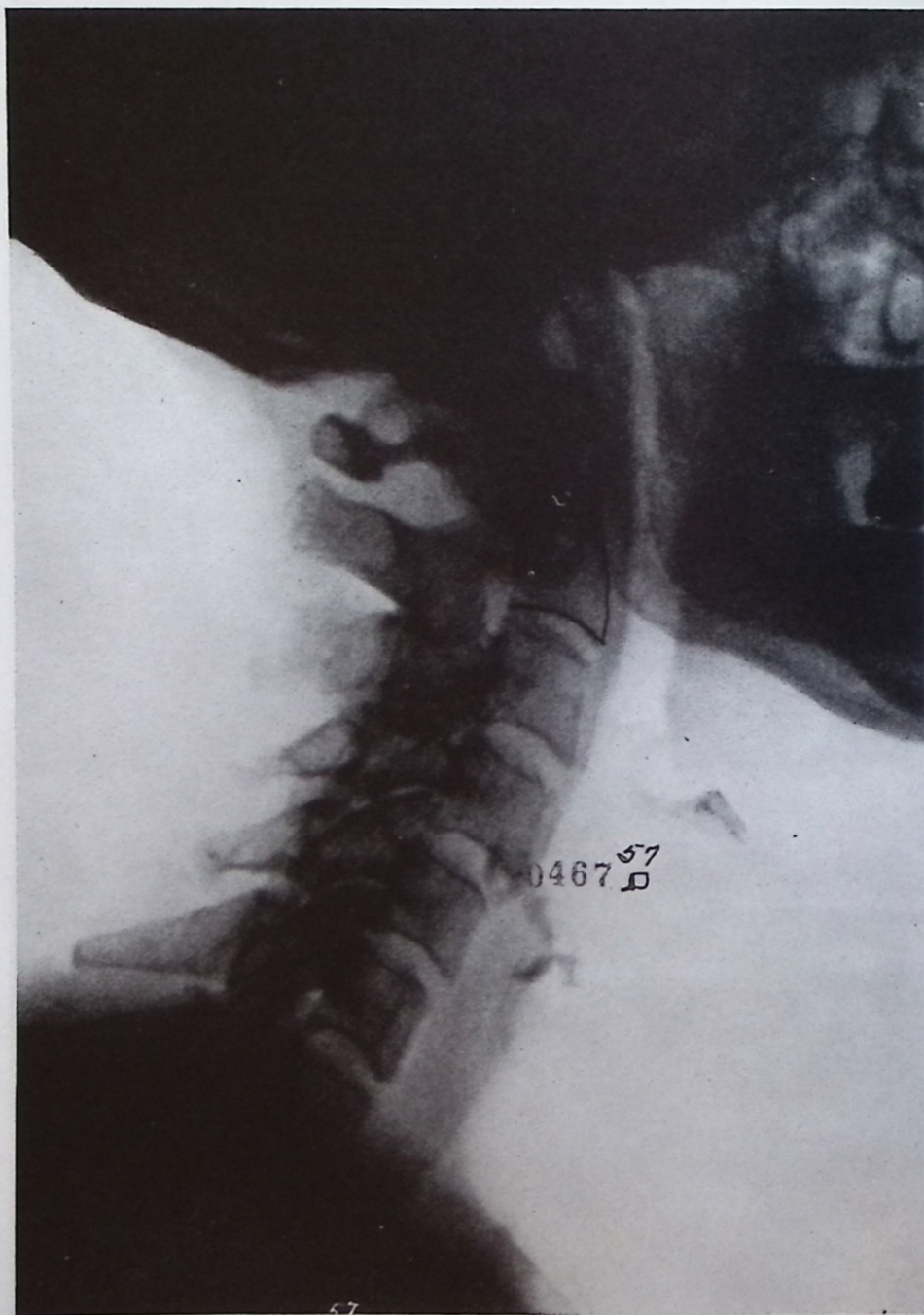


Illustration No. 467

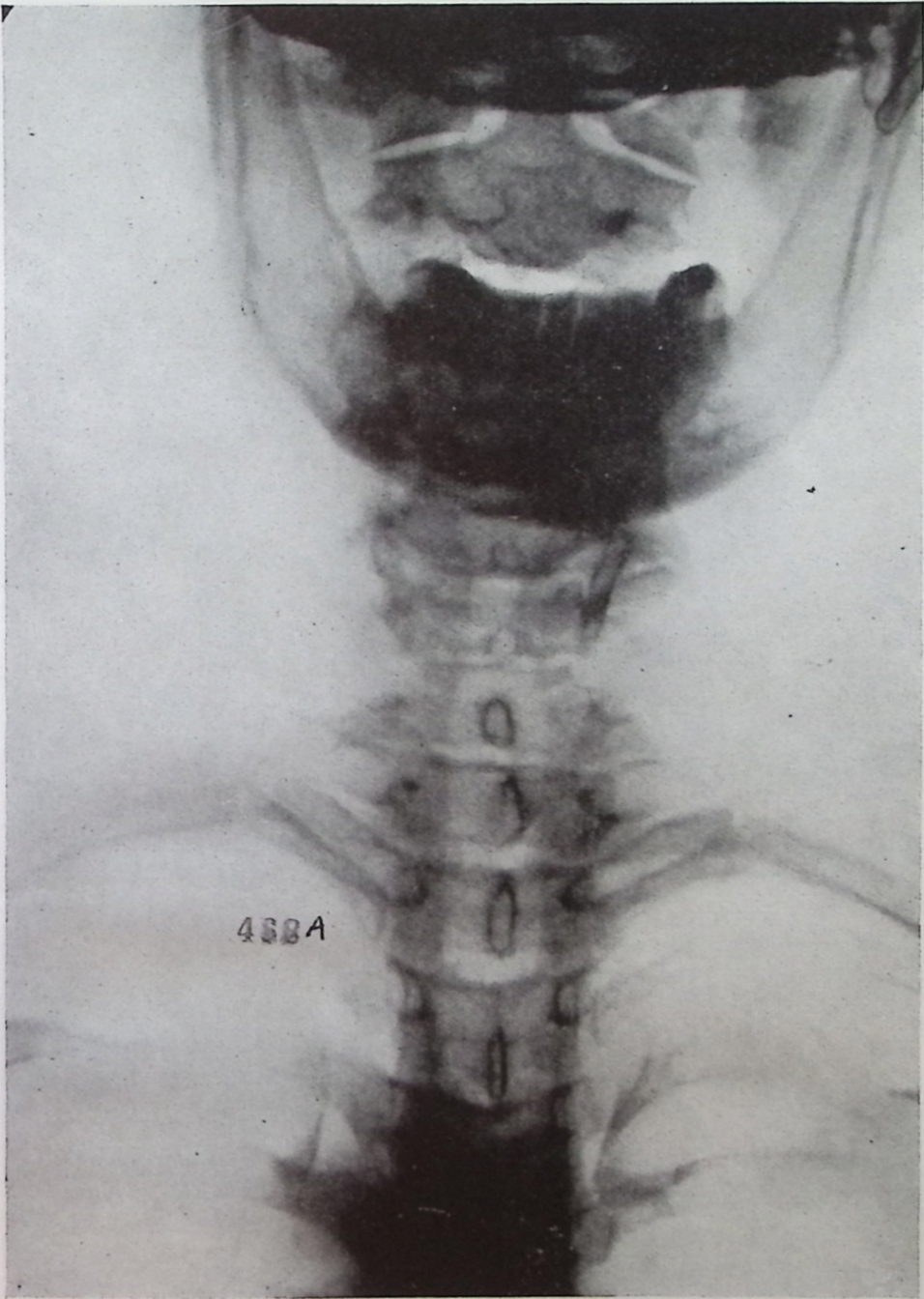


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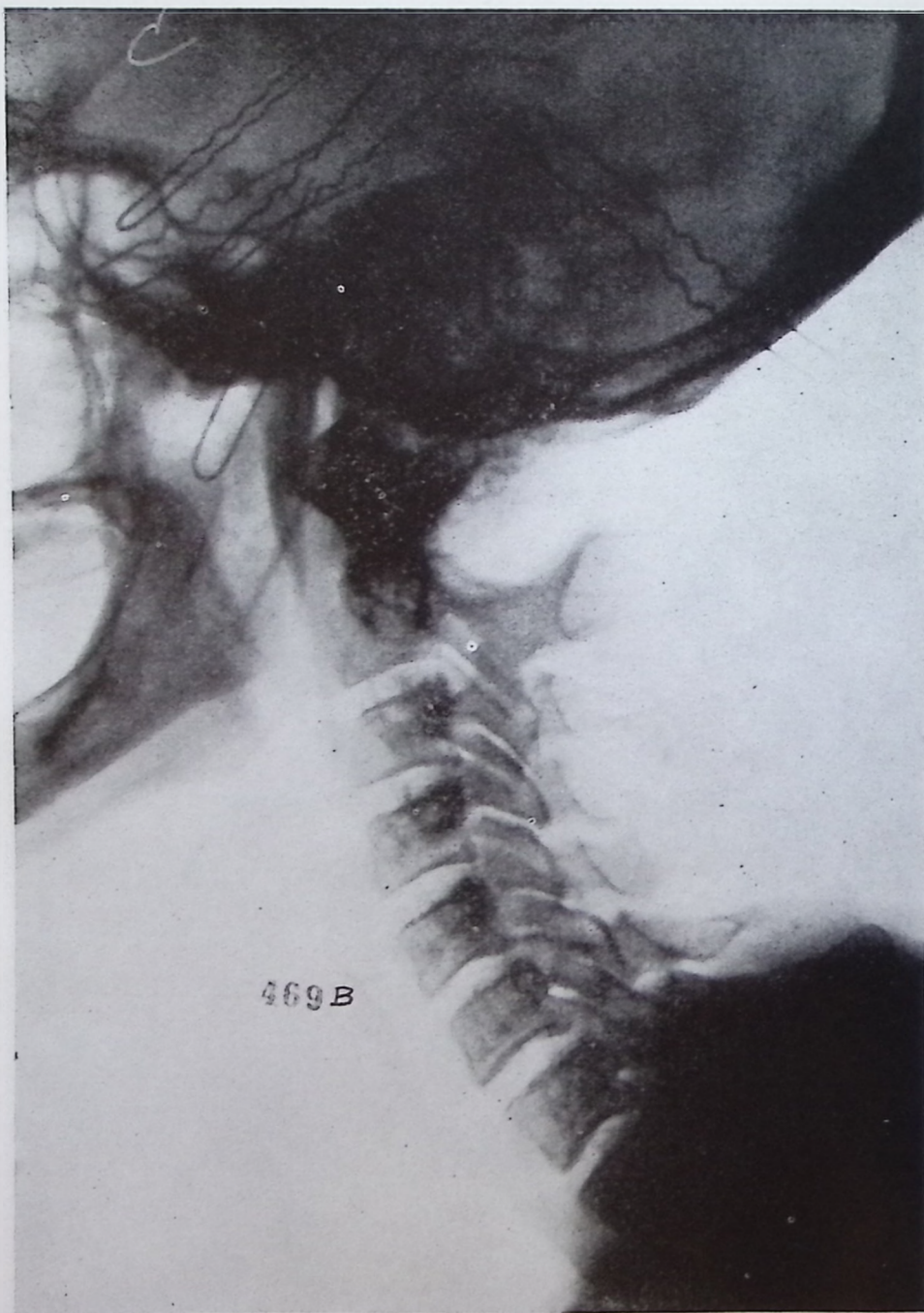


Illustration No. 469

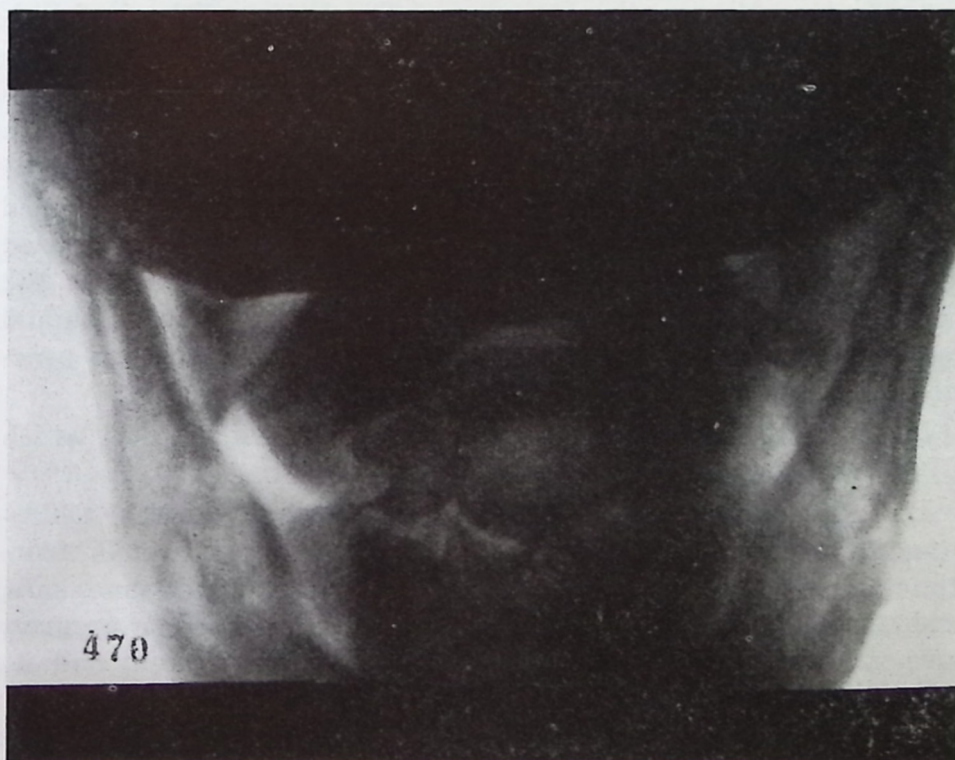


Illustration No. 470

CHAPTER XLIII

Analysis of HIO Scientific Application of Chiropractic in 5,000 Cases



D. PALMER DISCOVERED the principle of Chiropractic. He was the Founder of The Palmer School of Chiropractic, Davenport, Iowa. It was THE FIRST Chiropractic school, therefore "CHIROPRACTIC FOUNTAIN HEAD."

B. J. Palmer (son of D. D. Palmer) is the DEVELOPER of Chiropractic. He is and has been President of The Palmer School of Chiropractic, Davenport, Iowa. He is universally recognized by chiropractors, publishers, authors, and encyclopedias as the authority on things Chiropractic. It is befitting that he should carry on the family Chiropractic traditions, principles and practices of his father.

D. D. Palmer laid down the concept and fundamental in which B. J. Palmer had no part.

B. J. Palmer has developed practically every practical Chiropractic principle and practice which the profession has from time to time adopted and continued to use, as sound, sane, safe, and sensible, which has been incorporated as a part of a progressive growth. Among the many are the meric system and its improvement, majors and minors. Every successive step in the development of the adjustic art of Chiropractic, from the crude beginning, punch-'em-all-every day idea to the 1933 present Scientific adjust-only-the-vertebral-subluxation, when-it-is-a-subluxation, and not-adjust-when-there-is-nothing-to-adjust, when there is no subluxation, is the product of the scientific research from the clinical laboratories of B. J. Palmer; every step being tried, tested, proved before presentation to our profession. That accounts for the stability of the name "Palmer" in Chiropractic and on a "Palmer" school diploma. Hundreds of other adjustic techniques have come, lived awhile, and died aborning, possessing little if any scientific value, and created to sell to an all-too-

THE ADJUSTMENT SPECIFIC

unsuspecting innocent profession seeking improvement and a short-cut road to wealth.

B. J. Palmer introduced and named the (X-ray) Spinograph into Chiropractic in 1910. By its use, with a newly developed technique, Chiropractors KNOW with exactitude the incorrect mal-position of a vertebral subluxation.

B. J. Palmer introduced the Neurocalometer into Chiropractic in 1923. Its use has taken all guess out of specifically finding and proving the exact location, WHICH vertebra, WHERE located, is producing pressure upon nerves. Its use establishes competently WHEN it is and WHEN it is not; proves whether an adjustment WAS such or just another wrong punch somewhere in the back.

The evolution of information gained since 1910 with spinograph, and since 1923 with Neurocalometer, developed to that high efficiency, and in 1930 B. J. Palmer announced the "Hole in One" principle of practice of Chiropractic. Instead of incorrectly "adjusting" many places, with mental reservations of doubt of all, this new principle and practice proved the correctness of THE ONE necessary, and developed an adjustment that accurately and competently positioned it, restoring health with scientific precision.

The Chiropractic profession looked askance upon this new method. The change from guessing to knowing; from multiplicity of wrong places to one single correct place, was so radically different. PROOF was demanded.

The following is an analysis of 5,000 cases, asked for from practitioners who have studied and applied the "Hole in One" principle and practice after studying the method under the personal supervision of B. J. Palmer. That it is more than B. J. Palmer said, is obvious from proof herein deduced. The "Hole in One" scientific application of Chiropractic now makes it specifically possible for the competently educated and properly equipped Chiropractor to take worse cases and get them well quicker than at any period in Chiropractic history

Numerical and Percentage Analysis of 5,000 HIO Case Reports as Broken Down in Groups and Totals as Built Up

	700	1,300	Total 2,000	3rd 1,000	Total 3,000	4th 1,000	Total 4,000	5th 1,000	Total 5,000
Number of HIO Cases Reported to Date.....	700	1,300							
Number of Chiropractors Reporting HIO Cases.....	24	84	108	63	171	47	218	41	259
Average Number of Cases Per Chiropractor.....	29.17	15.5	18.5	15.83	17.5	21.33	18.33	24.39	19.3
Number of Cases Reporting Well.....	518	942	1,460	758	2,218	823	3,041	815	3,856
Per Cent of Cases Reporting Well.....	74	72.4	73	75.8	73.9	82.3	76	81.5	77.1
Number of Cases Reporting Improved.....	182	336	518	227	745	145	890	123	1,013
Per Cent of Cases Reporting Improved.....	26	25.8	25.9	22.7	24.8	14.5	22.2	12.3	20.2
Number of Cases Reporting No Improvement.....		4	4	7	11	24	35	14	49
Per Cent of Cases Reporting No Improvement.....		.3	.2	.7	.3	2.4	.8	1.4	.9
Number of Cases Not Reporting Results.....		18	18	8	26	8	34	48	82
Per Cent of Cases Not Reporting Results.....		1.4	.9	.8	.8	.8	.8	4.8	1.6
Number of Adjustments Given.....	5,094	8,951	14,045	10,007	24,052	10,410	34,462	10,041	44,503
Cases Not Reporting Number of Adjustments.....		63	63	45	108	24	132	38	170
Average Number of Adjustments Per Case.....	7.29	7.20	7.25	10.40	8.20	10.40	8.60	10.04	8.90
Atlas Adjustments	274	468	742	347	1,089	371	1,460	369	1,829
Per Cent of Atlas Adjustments.....	39	36	37	34.7	36.3	37.1	36.5	36.9	36.5
Axis Adjustments	401	724	1,125	597	1,722	571	2,293	579	2,872
Per Cent of Axis Adjustments.....	57.2	55.6	56.2	59.7	57.4	57.1	57.3	57.9	57.4
Third Cervical Adjustments.....	17	55	72	35	107	25	132	25	157
Per Cent of Third Cervical Adjustments.....	2.42	4.23	3.6	3.5	3.5	2.5	3.3	2.5	3.1
All Other Vertebrae, Including Occiput, Sac. & Coccyx.....	9	25	34	22	56	22	78	18	96
Per Cent of All Other Vertebrae.....	1.28	1.92	1.7	2.2	1.53	2.2	1.9	1.8	1.9

Number of Cases in Which No Major Was Stated.....	27	27	10	37	11	48	9	57
Per Cent of Cases Not Stating Major.....	2.07	1.35	1	1.23	1.1	1.2	.9	1.1
Number of Cases Where More than One Place Was Adjusted or No Major Stated	1	60	61	32	93	126	27	153
Number of Cases Adjusted According to Spinograph.....	496	585	1,081	566	1,647	2,063	501	2 564
Per Cent of Cases Adjusted According to Spinograph.....	70.8	45	54	56.6	54.9	51.5	50.1	51.2
Number of Cases Adjusted According to Palpation.....	185	484	669	342	1,011	1,474	438	1,912
Per Cent of Cases Adjusted According to Palpation.....	26.43	37.2	33.4	34.2	33.7	36.8	43.8	38.2
Number of Cases Not Reporting Whether Spgh. or Palp	19	231	250	92	342	121	61	524
Per Cent of Cases Not Reporting Whether Spgh. or Palp	2.7	17.7	12.5	9.2	11.4	11.5	6.1	10.4
Gross Time Reported on All Cases Where Time Under Observation Was Given—(In Days).....	48,236	87,887	136,123	75,764	211,887	273,939	67,326	341,265
Cases on Which Chiropractors Did Not Report Gross Time	103	103	79	182	125	307	85	392
Average Time on Each Case Where Gross Time Was Reported	68.9	73.4	71.6	82.2	75.1	72	73.5	72.7
Per Cent of Days to Get Cases Well or Improved as reported14	.085	.052	.108	.035	.114	.109	.021
Number of Visits Made, Including Days When Adjustments Were and Were Not Given.....	3,384	2,766	6,150	1,708	7,858	1,691	9,549	10,020
Number of Adjustments Given During These Visits, While Under Observation	1,169	285	1,454	536	1,990	532	270	2,792
Average Interval in Days Between Adjustments Per Visit and Per Adjustments Made	2.8	9.7	4.25	3.1	4	3.1	1.7	3.5
Total Time Stated for this Group of Cases While Under Observation as Stated—(Days)	8,841	2,766	11,607	3,767	15,374	16,798	2,570	19,368
Average Adjustment Given in this Group.....	1 in 7.05 days	1 in 9.7 days	1 in 8 days	1 in 7 days	1 in 7.7 days	1 in 2.6 days	1 in 9.5 days	1 in 6.9 days

What Is Proof?

PROOF of HIO, as a means of taking worse cases and getting them well quicker, is demanded.

Proof offered by any man directly interested is often challenged. Here is PROOF offered by disinterested Chiropractors, who have no interest in outcome except as it furthers the progress of Chiropractic.

A study of these reports PROVES that, with rare exception, HIO WAS EXCLUSIVELY USED.

In this report Chiropractors do not make statement that EVERY case in their practice is strictly a HIO case. The majority ARE working exclusively HIO system on ALL cases. Some of these Chiropractors occasionally use meric system on a case; but by far largest majority ARE HIO.

A study of statements issued by Chiropractors shows in all cases determination of location for adjustment was made by NCM and in a majority, position was determined by SPGH and was NOT based on symptomatology, history, or diagnosis, made by themselves or physicians.

A study of the symptomatology, pathology, history, and diagnosis as reported in these cases, PROVES that almost every imaginable disease is listed—running the gauntlet from acute to long-standing chronic types. Letters reveal, in the vast majority of cases, diseases listed were reported by case or physician and not ascertained by the Chiropractor; he not being interested from that viewpoint.

A study of these reports PROVES the majority of Chiropractors used little, if any, diagnosis, diagnostic instruments, or methods; did not try to ape medical men or simulate themselves as such. In practically all cases, only the HIO method of spinal analysis was used, proving it stands independent and can be relied upon exclusively.

A study of these reports PROVES that nothing but Chiropractic principles and practices were used, including NCM to LOCATE interferences; SPGH to determine POSITION; toggle-recoil adjustment, and NCM to prove correctness of adjustment—all of which were efficiently, competently, accurately, and honestly rendering an all-Chiropractic service.

What IS proof? If investigator's mind is pre-judging, maliciously denying facts, does not seek truth, is deliberately blinding his mind to evidence, then 10,000 cases could not break down the barrier. There are men who prefer horse and buggy and deny the possibility of flying. There are Chiropractors who refuse to investigate the SPGH, preferring to rely upon fingers. They will die denying the NCM.

What IS proof? If one demands PHYSICAL proof of the presence or absence of physiological function, it would be impossible to PROVE any case, to any person; through publications, by mail, at a distance. That which would constitute PROOF to the Chiropractor who had the case from beginning to end, would not be proof to any other person at a distance, who did not have the case under constant observation.

What IS proof? If one studies principle, applies practice and it works, is THAT proof? Isn't that the way all PROOF begins, is, and always ends? Mental conclusion, based on facts and evidence, are PROOF when deduced. If THIS be PROOF, it can be PROOF with statements that can be relied upon as true and truthful. If this be proof, how many cases must be piled up to demonstrate it?

What IS proof? Regardless of physical conditions, mental conclusions of the Chiropractor are not the opinion OF THE PATIENT. The patient alone has the ONLY proof, for THE CASE KNOWS when she was sick; when she became well. How else can another on the outside PROVE anything on the inside of another? A physician can diagnose "pain", but he cannot PROVE the presence of "pain" in another; neither can he PROVE its absence.

Numerical and Percentage Analysis

Number of different Chiropractors reporting HIO cases in this analysis	259
Average number of cases per Chiropractor.....	19.3
Number of HIO cases reporting in this analysis.....	5,000
Number of cases reporting WELL.....	3,856

(Never before in Chiropractic history have Chiropractors been able to prove such an overwhelming majority of cases WELL in such a large international survey, as a direct result of one specific method, exclusively applied. Only once before was a sincere at-

tempt made at an honest survey, to ascertain statistics; and at that time (1910) proved that only 35% of cases got well under the meric system and majors and minors.)—(See REASONS FOR MY FAITH—B. J. Palmer).

Number of cases reporting IMPROVED..... 1,013

(Never before in Chiropractic history have Chiropractors been able to definitely KNOW the gross failures of a gross number of cases that were IMPROVED but not well, by comparison, as this analysis reveals.)

Number of cases reporting NO IMPROVEMENT..... 49

(Never before in Chiropractic history have Chiropractors been able to definitely KNOW the gross failures of a gross number of cases, as this analysis reveals true with the accurate use of one definite HIO system, as compared with other past and present general methods, claimed superior. Every new idea, move, method, or system originated, born, peddled about to our profession, makes claims. They come; they go. Hundreds of them are strewn by the wayside. Hundreds of thousands of dollars have been thrown away, getting them. The HIO proves value by this analysis, verified by printed cases of which it is composed.)

Number of cases not reporting results — whether better or worse, lived or died..... 82

3,856 cases WELL is 77.1% of 5,000 cases.

1,013 cases IMPROVED is 20.2% of 5,000 cases.

49 cases NO IMPROVEMENT is .9% of 5,000 cases.

82 cases not reporting results is 1.6% of 5,000 cases.

Cases not reporting number of adjustments..... 170

Number of adjustments given in this analysis..... 44,503

Average number of adjustments per case to get 3,856 cases WELL and 1,013 IMPROVED..... 8.9

8.9 adjustments per case to get either 3,856 WELL or 1,013 IMPROVED is .019% of 44,503 adjustments.

(Never before in Chiropractic history have Chiropractors been able to give so few ADJUSTMENTS to get such a large majority of cases WELL or IMPROVED. In the past, the average Chiropractor using meric system or majors and minors, would average five places of thought-to-be "adjustment" daily, six days a week, covering months—three being a fair average. Exclusive of Sundays, 78 days x 5 places equals 390 "adjustments", which would be a low average under older methods. Contrast 8.2 HIO adjustments to INCREASE health, as against 390 "adjustments" to delay health or 65% fail.)

ATLAS adjustments 1,829

AXIS adjustments 2,872

3rd CERVICAL adjustments..... 157

All other vertebrae, including occiput, sacrum, and coccyx 96

Number of cases in which no major was stated..... 57

96 cases with different places of adjustment, in 5,000 cases proves that only a possible 96 were adjusted at more than ONE place. (It is fair to state in this analysis that the most of the "extra" UNNECESSARY places were confined to CERTAIN FEW persons who had not yet perfected themselves in HIO technique.)

Number of cases where more than one place was adjusted or no major stated.....	153
Number of places adjusted per case.....	1 in 4,847
4,847 cases adjusted one place only is 96.9% of 5,000 cases.	
1,829 Atlas cases out of 5,000 is.....	36.5%
2,872 Axis cases out of 5,000 is.....	57.4%
157 3rd Cervical cases out of 5,000 is.....	3.1%
96 cases with different places adjusted, out of 5,000 is.....	1.9%
57 cases out of 5,000 in which no major was stated is	1.1%

(Never before in Chiropractic history have Chiropractors been able to definitely and specifically make such a comprehensive and far-reaching survey of so large a number of cases, in which definite and specific places were only and exclusively adjusted, to prove that ONE vertebral adjustment could and did prove the singleness of dis-ease and cure and the correctness of a certain set-forth principle and practice. In the past, and even present, some Chiropractors "adjust" any vertebra, or ALL vertebrae, and erroneously jump to the faulty conclusion, as fact, thinking thus to "prove" this, that, or some other general all-over system as THE correct one. By contrast, the Spears system "adjusts" 25 vertebrae (atlas to coccyx) three times up one side, 3 times down the other, several times daily; one follower suggesting doing so every 15 minutes. Such promiscuous spinal-overhauling mauling could not specifically prove any specific scientific principle or practice. The extreme, marked, contrasting value between the single HIO one-place adjustment, and all other methods, is that it DOES NOT do much; that the much is far more injurious than the little.)

If they "adjust" once each day, it has 1/30th the staying value against one adjustment in 30 days.

If they "adjust" one place only, every 15 minutes, it has 1/96th the staying value as against "adjusting it once every 24 hours.

If they "adjust" 24 vertebrae in one day, it has 1/24th of the accident of being right.

If they "adjust" 24 vertebrae every HOUR of the day, the error of judgment increases to 1/576th of being correct.

If they "adjust" 24 of them, every 15 minutes, 30 days in the month, the refraction has multiplied to 1/17.280th of being correct IF THE CHIROPRACTIC PRINCIPLE BE "SANITY IN CHIROPRACTIC," which "IS THE MOST VITAL NEED OF OUR PROFESSION."

By inverse ratio, the opposite would be true.

If THE subluxation is efficiently, correctly, competently, and honestly located; is ADJUSTED ONCE and remains adjusted for 30 days, not needing further "treatment" upon itself, any other place, at any other time, then he has reversed the above destructive values by turning on the continuous flow of mental impulse supply into a constructive restoration of health that much faster.

1/30th faster than he who adjusts one place EVERY DAY for 30 days.

1/24th more accurate than if he "adjusted" 24 every day.

1/96th faster than he who "adjusted" one place every 15 minutes of the day.

1/576th faster than if they "adjusted" 24 of them every hour of the day.

1/17,280th faster than if they adjusted 24 of them every 15 minutes of the day, for 30 days.

The difference between the accumulative DESTRUCTIVE survival value and the accumulative CONSTRUCTIVE survival value is brot about by KNOWLEDGE that the efficient, competent, accurate, and honest use of the NCM with its HIO system gives.

If I adjust one vertebral subluxation twice, and the case gets well, the first time WAS A FAILURE.

If I "adjust" one vertebral subluxation 24 times, 23 times I failed.

If I "adjust" 24 vertebrae once every 30 days; then I admit every day, 24 times BY REPEATING MY FAILURE, that I did NOT give AN ADJUSTMENT.

If I "adjust" 24 vertebrae every 15 minutes of 24 hours, then 95 times, BY REPETITION, I ADMIT THAT I DO NOT KNOW WHERE OR WHEN to give an adjustment.

We are rapidly evolving out of the many place backbone treatment method; passing thru the multiple location adjusting idea, into a one-place, once specific adjustment. Chiropractic is getting purer and growing stronger yearly. Chiropractors are splitting into two groups; those who are getting worse as general, all-backbone adjusting-masseurs; relieving or alleviating symptoms; and those who are learning HOW to give ONE adjustment, ONCE and get their case WELL.

Number of cases adjusted according to Spinograph..... 2,564

Number of cases adjusted according to Palpation..... 1,912

Number of cases on which no report was stated as to
Spgh. or Palp. 524

2,564 cases adjusted according to SPGH. is 51.2% of 5,000 cases.

1,912 cases adjusted according to PALP. is 38.2% of 5,000 cases.

Compare 3,856 cases reporting WELL with the figure of 2,564 adjusted according to Spinograph.

Compare 1,013 cases reporting IMPROVED with the figure of 1,912 adjusted according to Palpation.

This comparison of 51.2% by spinograph, as against 38.2% by palpation, proves the difference of 13% advantage in results of Spinograph over palpation.

(Never before in Chiropractic history have Chiropractors been able to secure and have optical proof of a photographic picture of the each and every position of a vertebra, in living sick bodies, that he could KNOW specifically and exactly the mal-position of vertebrae, to KNOW WHERE, HOW, and WHEN to give correct adjustments. Contrast feeling with fingers on the outside of the human flesh, of that which is buried down deep in the inner tissues; as against spinographic photographic pictures taken from that down-deep inside, thus eliminating guess work. This analysis PROVES, for the first time, the superiority of the spinographic method of ascertaining positions of vertebrae, as against palpation, in a larger number of cases.)

Out of 259 Chiropractors whose cases comprise this analysis, 203 stated they used HIO system exclusively, in their offices. This proves that cases listed are not culled, hand-picked, choice, and only favorable, successful ones.

(Never before in Chiropractic history have Chiropractors been able to prove a definite principle and practice, as definite in its conclusions, as definite in exclusion of anything contrary to it, so universal in its application extending from the countries of Europe, Canada, States of the United States, to Hawaii, New Zealand, and Australia, etc.; that people, back-bones, subluxations, adjustments, Innate and health are without nationality, color, or creed; and that a Chiropractor can apply a positive principle and practice and prove its universal worth one place as well as another and thus is a human-race service, if Chiropractors were universally vertebral-subluxation-minded and scientific-adjustment-conscious.)

Gross time reported on all cases where time was reported,
while under observation, computed in days.....341,265
Cases on which Chiropractors did not report time..... 392
Average per case time on each of 4,608 cases while under
observation, where gross time was reported (days) 72.7
72.7 days average to get 3,856 cases WELL and 1,013 IM-
PROVED is .021% of 341,265 days.

(Never before in Chiropractic history have Chiropractors been able to take a gross number of cases, keep an exacting record of the gross time the cases were under observation, and reduce this time from years to months, and now to days, averaging 72.7 days for the entire time while under observation to get 3,856 cases WELL and 1,013 IMPROVED—a 4,869 out of a possible 5,000, including practically every dis-ease possible in a human body. This analysis is based on actual case reports sent us, based on actual office case records, kept by Chiropractors who sent them. Fickle memory has had nothing to do with this analysis.)

Gross number of visits made, including days when adjust-
ments were and were not given, as reported in this
group 10,020

Number of adjustments given during these visits..... 2,792

Average interval in days between adjustments PER VISITS
AND ADJUSTMENTS MADE, approximately 3.5.

(Never before in Chiropractic history have Chiropractors been able to so thoroly eliminate the element of guess in arriving to such a scientific point to where the interval averaged 3.5 days between calls over a gross of 4,869 cases.

(In former days, it was "punch" not less than 5 places EVERY day, for months.)

Total time stated for this group of cases while under observation, as stated, 19,368 days.

Average adjustment given in this group while under observation FOR FULL TIME stated—1 in 6.9 days.

(Never before in Chiropractic history have Chiropractors been able to reduce uncertainty and guess-work, down to a specific knowledge of adjusting ONE place, scientifically and exactly picked, adjusted on a gross average of once in 6.9 days' interval, proving that he KNOWS WHEN a subluxation is, or is not present; WHEN to adjust and WHEN NOT—thus doing that only when that was present, accumulating health values by eliminating accumulative destructive values by not creating them by not doing something many times, many places, wrong.)

This report shows that out of 5,000 cases, 3,856 got WELL and 1,013 IMPROVED, by adjusting ONE place only in 4,904 cases and TWO or more places in 96 cases, with an average of 8.9 adjustments per case, with an average adjustment given 1 in 6.9 days; where ATLAS ONLY was adjusted in 1,829 cases; AXIS ONLY in 2,872 cases; 3rd CERVICAL ONLY in 157 cases; 96 other places in other cases; Spinograph being used in 2,564 cases and palpation in 1,912 cases.

The report further proves that the NCM was 100% exclusively used, as the efficient, competent, accurate, and honest means used on 5,000 cases to locate the interference and determine the place of and for adjustment.

Analysis of Dis-eases of this 5,000 HIO Case Report

The following alphabetical and numerical listing of dis-eases is the breaking down analysis of 5,000 HIO cases. HIO system finds no necessity for approaching the problem of dis-ease and its solution with health, from any use of symptomatology, pathology, history, or diagnosis of any case. In this analysis, we

accepted names or diagnoses, as offered by cases, physicians, or Chiropractors. Dis-eases, as named and listed, are secured mostly from physicians who had the case preceding going to a Chiropractor; patient so stating to the Chiropractor or secured from information imparted by patient direct as he or she felt. In this analysis, diseases are listed, therefore, under common names such as a patient would understand his or her condition to be. In this list, we assume no responsibility for accuracy in diagnosis.

The HIO scientific Chiropractor approaches the problem of getting his patient well from THE SPECIFIC CAUSE and its adjusting, gaining information by the use of his scientific spinal instruments. The case could be 100% wrong IN DIAGNOSIS and be 100% correct in SPINAL ANALYSIS AND ADJUSTMENT and get well.

Where possible, analysis shows subdivisions as to portion of body involved. In this event, numerical listing is not doubled, but subdivided, the first figure showing totality; second subdivision of areas involved. For example: "Hernia—7." One case mentioned "Hernia" was "Umbilical". The umbilical hernia was one of the seven originally listed; preventing duplication.

They have been alphabetically listed for reference.

Abdominal Cramps.....	1	Acne	14	Anterversion of	
Distension	2	Acute Appendicitis	39	Uterus	1
Pains	15	Bronchitis	2	Apoplexy	10
Rupture	1	Indigestion	4	Appendicitis	46
Abnormal Heart		Infection of Right		Aphonia	17
Action	2	Hand	1	Appendectomy	3
Leg and Arm.....	1	Inflammation of		Arhythmia	1
Abortion	1	Kidney	1	Arm Burns	1
Abscess of Inner Ear	2	Lumbago	5	Arms and Fingers	
Ears	2	Neuritis	1	Numb	1
Right Ear	1	Orchitis	1	Arterio Sclerosis	2
Buttocks	1	Adenoids	1	Arthrophyma	1
Kidney	1	Adhesions	2	Arthralgia	1
Left Ilium	1	Adhesions Following		Articular Rheuma-	
Left Mastoid	1	Appendectomy	1	tism	4
Ovary	1	Affected Speech	1	Arthritis	50
Uterus	1	Albuminurea	2	Of Hips	1
Lung	1	Allopecia	1	Lumbar Region	1
Absentmindedness	1	Amnesia	2	Spinal Column	1
Ache between		Amenorrhea	12	Right Arm	2
Shoulders	1	Anal Fissures	1	Hands, Feet, Knees	3
Aching in Dorsal		Anorexia	112	Right Knee	7
Region	1	Angina Pectoris	7	Left Knee	5
Joints	1	Ankylosis of Dorsal		Both Hands	6
Arms and Limbs.....	1	And Lumbar		Cervical Region	1
Lower Extremities..	1	Region	1	Femur	1
Neck and Lower		Left Elbow, Wrist,		Legs	1
Back	1	Fingers	1	Feet	3
Bones	1	Between Atlas and		Sacro Illiac Region	1
Scapulae	1	Axis	1	Neck	2
Entire Body	1	Anemia	20	Knee	1
Acid in Urine.....	1	Aneurism of Aorta.....	1	Elbow	1
Acidosis	6			Fingers	1

Arthritis Deformans..	5	Both Breasts	1	Club Hands	1
Asthma	75	Breast	2	Foot	1
Astigmatism	3	Femur	1	Coated Tongue	1
Athlete's Foot	1	Mouth	3	Cold Hands	1
Auto Intoxication	2	Lower Abdomen ...	1	Feet	1
Auria	1	Right Arm and		Colds	90
Baby Entirely Help-		Shoulder	1	In Head and Chest	3
less	1	Tongue	1	Cold Sensation in	
Backache	138	Spine	1	Back of Neck.....	1
Back Injured	6	Urethra	1	Colitis	21
Back Pains	8	Uterus	1	Color Blind	1
Bad Back	1	Cancerous Growth of		Coma	8
Cold	9	Generative Organs..	1	Compound Curvature	1
Color	1	Canker Sores	1	Complete Deafness...	1
Cough	5	Cardian Incompe-		Paralysis, both	
Eyes	11	tency	2	Sides	1
Dreams	1	Stricture	1	Concussion 1st Lum-	
Heart	1	Pains	1	bar Vertebra	1
Bartholin Abscess ..	1	Trouble	1	Of Brain	1
Basilar Headaches ..	1	Palpitation	1	Congenital Deformi-	
Bed Sores	1	Dropsy	1	ty of Hips and	
Wetting	11	Carditis	2	Generative Or-	
Belching of Gas.....	4	Cataract	2	gans	1
Bent Spine	1	Catarrrh	33	Congested Feeling in	
Billousness	23	Of Stomach	1	Head	1
Black Erysipelas ..	1	Of Respiratory		Congested Cervical	
Bladder Trouble	17	Tract	1	Lymphatics	1
Bitter Oily Taste in		Catarrhal Deafness..	7	Gall Bladder	2
Mouth	1	Headaches	6	Congestion of Lungs	1
Blindness	19	Bronchitis	2	Left Antrim	1
In Right Eye	5	Carcinoma	1	Chest	1
In Left Eye	3	Cerebral Hemorrhage	1	Congestion and Knot-	
Blood Poisoning	1	Cervical Glands ..		ting of Muscles	
Blood in Urine	2	Swollen	3	at Base of Skull..	1
In Sputum	1	Cervical Pains	2	Conjunctivitis	1
Blue Baby	1	Chest Colds	6	Constant Pain in	
Blisters on Legs.....	1	Pains	3	Dorsal Region.....	2
Bloating of Abdomen	2	Chicken Pox		Perspiration	1
Bleeding Hemmor-		(Varicella)	1	Tenderness and	
hoids	4	Chills	2	Pain in Entire	
Blind Boils	1	Chlorosis	1	Body and Spine..	1
Blurring of Eyes	1	Chorea	42	Menstruation	6
Boils	7	Of Facial Muscles..	1	Dreaming	1
Bones Break Easily..	1	Cholic	1	Fever	1
Bowels Passive	2	Chronic		Cough	2
Bowel Trouble	8	Diarrhea	4	Colds	3
Brain Tumor	3	Appendicitis	18	Headaches	1
Bright's Disease	5	Bronchitis	5	Vomiting	1
Brachial Neuritis	1	Asthma	3	Constipation	698
Breast Tumor	1	Arthritis	2	Continually Sleepy...	1
Broken Jaw	1	Backache	3	Crying	1
Bromidrosis	1	Bronchial Cough ...	1	Coccygeal Pains	6
Bronchial Asthma	7	Constipation	14	Contraction of Cer-	
Pneumonia	2	Constriction of		vical Muscles.....	1
Cough	12	Cardiac Muscles ..	1	Muscles of Neck...	5
Neuritis	1	Cough	6	Neck and Shoulder	
Trouble	9	Milk Leg	1	Muscles	1
Bronchitis	39	Ulcers of Stomach..	1	Muscles of Feet	
Bulimia	2	Headaches	15	and Legs	1
Burning Pain in		Heart Trouble	1	Facial Muscles	1
Right Thumb	1	Interstitial		Muscles of Lower	
Over Kidneys	1	Nephritis	1	Back	2
Burning Sensation		Gastritis	1	Muscles of Entire	
In Stomach	1	Liver Trouble	1	Body	1
In Bladder	1	Mastoiditis	1	Colitis	18
In Back	1	Nephritis	1	Coryza	34
During Urination ..	20	Neuritis	1	Costiveness	3
Bursitis	1	Nervousness	1	Convulsions	8
Buzzing in Ears.....	1	Rhinitis	1	Coughs	8
Catch in Small of		Rotation of Head...	1	Cranial Dryness	1
Back	1	Sciatica	2	Headaches	5
Cachexia	1	Sinusitis	2	Cramps in Limbs	1
Callouses on Balls		Stomach Trouble ...	2	Right Foot	1
of Feet	1	Choking Sensation		Left Foot	1
Cancer	2	in Throat	5	Lower Abdomen	5
Of Bladder	3	Clay Colored Stool...	1	Cretinism	1
Bowels	1	Clouded Vision	1	Crossed Eyes	8

Cystic Tumor	1	Dyspnea	26	Facial Pain	1
Cystitis	44	Dysuria	6	Facial Paralysis	23
Cystoethiasis	8	Earache	8	Tumor	1
Cystolic Murmur	1	Ear Trouble	3	Neuralgia	2
Dazed Condition	1	Ear and Nose	1	Fallen Arches	3
Deafness	28	Trouble	1	Fainting Spells	
in One Ear	2	Ear Infection	1	(Syncope)	13
In Right Ear	4	Eczema	20	Failing Eyesight	3
In Left Ear	2	Of Limbs	1	Fall from Tree	1
Deformity of Joints		Hands	3	Falling Hair	1
of Fingers	1	Face and Abdomen	2	Female Trouble	22
Deglutition—Painful	1	Limbs and Torso	1	Feet and Hands	
Delirium	3	Hands and Feet	1	Swollen	1
Dementia Praecox	2	Fingers and Toes	1	Feet Swollen	3
Developing of Paral-		Arms	1	Feces Pencil Size	1
ysis — Arms and		Universalis	2	Fever	29
Legs	1	Under Left Arm		Fibroid Tumor	1
Diabetes	1 ¹	and Between		Fibroid Tumor of	
Diabetes Mellitus	25	Toes	1	Uterus	3
Diarrhea	9	Edema of Left Leg		Firmness and Pain in	
Dilation of Eusta-		and Ankle	1	Left Breast	1
chian Tube of		Edematous Ankles	2	Fistula (umbilicus)	2
Bowels	1	Edematis	1	Flow of Saliva	1
of Heart	2	Educated Voluntary		Frontal Headaches	33
Difficult Speech	1	Muscular Incoor-		Frontal and Occipital	
Breathing	4	dination	1	Headaches	1
Walking	3	Emaciation	59	Frequent Urination	4
Diphtheria	1	Emesis	34	Colds	1
Diphtheric Sore		Empyema	1	Menstruation	2
Throat	1	Endocarditis	2	Furunculosis	2
Discharge from Eye	1	Encephalitis	1	Gall Bladder Trouble	11
Ear	6	Encephalitis		Gastralgia	2
Frontal and Max-		Lethargica	2	Gastritis	92
illary Sinus	1	Enlarged Thyroid	4	Gastric Spasms	1
Fallopian Tubes	1	Prostate	3	Cancer	2
Distension of		Tonsils	6	Fermentation	8
Abdomen	1	Liver	1	Ulcers	23
Discoloration of Skin	2	Adenoids	1	Pains	3
Distended Transverse		Abdomen	1	Gas Pains	4
Colon	1	Cervical Glands	1	In Stomach	18
Dislocated Knee	1	Heart	3	In Intestines	1
Dislocation between		Spleen	1	In Left Epigastric	
8th and 9th Dor-		Parotoid Gland	1	Region	1
sal	1	Enteritis	8	Gastric and Intestinal	
Disseminated		Enteroptosis	1	Indigestion	1
Sclerosis	1	Epicranial Pressure	1	Gastroptosis	1
Divergent Strabismus	1	Epilepsy	41	General Aching	2
Dizziness	53	Epistaxis	2	Debility	57
Dorsal Pains	9	Exophthalmic		Asthenia	1
Weakness	1	Goitre	9	Emaciation	2
Double Scoliosis	1	Exhaustion	2	Fatigue	1
Vision	4	Exostosis of Cervicals	1	Neuritis	4
Inguinal Hernia	4	Erysipelas	3	Numbness	1
Drawing Sensation		Erythemia	2	Pain in Whole	
Along Spine	1	Excess Perspiration	1	Body	1
Between Shoulders	1	Excessive Urination	1	Paralysis	2
Dribbling of Urine	2	External Goitre	1	Rheumatism	1
Dropsy	6	Extreme Lethargy	1	Run Down Condi-	
In Leg	1	Backaches	2	tion	1
Left Leg	1	Irritability	1	Stiffness in Neck	
Dropped Palate	1	Nervousness	10	and Spine	1
Dropping of Testicles	1	Weakness	3	Tired Feeling	1
Drawn Facial		Extremely Bad		Toxic Condition	1
Expression	1	Posture	1	Weakness	21
Dryness in Posterior		Stooped	1	Gall Stones	14
Pharynx	1	Eye Blood Shot	1	Gangrene	1
Drowsiness	1	Pains	3	In Right Foot	2
Dry Cough	1	Strain	4	Grinding Noise in	
Skin	6	Tick	1	Neck while Turn-	
Duodenal Ulcers	10	Trouble	39	ing Head	1
Pains	1	Weakness	8	Glandular Throat	
Dumbness	1	Watering	1	Trouble	1
Dyctis Calcule	1	Face Paralyzed Due		Giddiness	3
Dysentery	1	to Antitoxin	2	Gout	1
Dysmenorrhea	107	Face and Chest Burn	1	Greenish Complexion	1
Dysphagia	8	Face and Neck Badly		Glaucoma in Right	
Dysphonia	18	Swollen	1	Eye	2

Glossitis	1	Infected Throat	1	Jerking of Head and Neck	1
Goitre	35	Inflammation of Right Eye	3	Kidney Trouble	80
Gonorrhea	9	Extremities	1	Stones	13
Gonorrhea Rheumatism	1	Lungs	1	Pains	4
Grand Mal	4	Testes	1	Kidneys Inactive	6
Granulated Eyelids	2	Kidney	2	Kyphosis	1
Grating of Teeth	1	Right Thumb	1	Lack of Energy	74
Growth in Nose	1	Eyes and Lid	1	Lack of Saliva	1
In Forearm	1	Chest	1	Lame Back	87
Haacking Cough	1	Rectum	1	Arms	1
Halitosis	6	Bladder	4	Shoulder	2
Hands Drawn	1	Left Ovary	1	Knee	2
Hay Fever	52	Inability to Walk	4	Lameness in Left Hip	2
Headaches	751	To Retain Urine	2	Laryngitis	4
Head Drawn to One Side	3	Infection of Frontal Sinus	1	Laryngismus Stridulus	1
Head Noises	16	Left Eye	1	Lateral Hemiplegia	1
Pains	16	Palm of Hand	1	Lassitude	6
Colds	4	Right Mastoid	1	Leakage of Heart	10
Heart Burn	1	Right Eye	1	Left Arm and Hand Withering After Antitoxin Innoculation	1
Pains	3	Inflamed Laceration	1	Left Ankle and Foot Badly Swollen and Discolored	1
Trouble	80	Prostate Gland	2	Leg Pains	8
Murmur	1	Inflammatory Rheumatism	12	Lethargy	1
Heaviness in Chest	1	Of Right Foot	1	Leukorrhea	16
Hard Lump over Stomach and Liver	1	Of Entire Body	1	Lead Poisoning	1
Hematemesis	3	Influenza	43	Listlessness	1
Hemiplegia	8	Influenza Relapse	1	Limited Motion of Back of Neck	1
Hemophelia	1	Inguinal Hernia	7	Liver Trouble	21
Hemorrhoids	92	Inguinal Pains	1	Loss of Control of Urine	2
Hemorrhage	2	Injury to Upper Cervical Region	2	Of Appetite	10
Hemorrhage of Mouth and Rectum	1	Neck and Shoulders	6	Weight	40
Of Stomach and Bowels	2	Lumbar Region and Right Knee	1	Voice	2
Uterus	1	Sacro Iliac Articulation	1	Hearing	3
Eye	1	Lower Limbs	3	Sleep	22
Bladder	1	Knee	1	Sight	1
Urethra	1	Neck and Back	2	Sight of Left Eye	3
Throat	1	Coccyx	2	Sight of Right Eye	1
Hepatositis	1	Sacrum and Coccyx	1	Use of Both Legs	3
Hernia	8	Lumbar Region	3	Use of Left Arm	1
Of Left Side	1	Lower Spine	3	Equilibrium	4
Umbilical	1	Arm and Shoulders	2	Sexual Function	1
Herpes Zoster	4	Insanity	15	Memory	8
Hiccoughs	7	Insomnia	208	Muscle Control of Left Leg	1
High Blood Pressure	66	Instrumental Birth	1	Motion of Head	1
High Fever	18	Intercostal Pains	6	Taste and Smell	2
Hip Bone Disease	1	Internal Hemorrhoids	1	Muscular Tonicity of Knees	1
Hips Slip Out of Sockets	1	Interstitial Nephritis	1	Salivary Control	1
Hives	1	Intestinal Influenza	3	Use of Right Leg	1
Hoarseness	2	Obstruction	1	Control of Sterno-Cleido Mastoido Muscle	1
Hot Flashes over Body	2	Spasms	1	Control of Bowels and Kidneys	1
Humming in Ears	1	Fermentation	1	Locomotor Ataxia	1
Hydrocephalus	4	Hemorrhage	1	Low Blood Pressure	14
Hyperacidity	2	Paralysis	1	Low Resistance	3
Hypertension	10	Ulcers	1	Lumbago	196
Hyperdrosis	1	Irregular Heart	2	Of Hip	1
Hyperchlorhydria	7	Menstruation	7	Lumbar Pains	21
Hypertrophy of Left Ventricle	1	Appetite	1	Neuralgia	1
Hysteria	11	Irritable and Irresponsible	3	Lumbo-Sacral Pain	1
Idiocy	1	Itching and Burning Sensation of Urinary Tract	1	Lump on Left Breast	3
Iliac Pains	1	Itching Over Entire Body	4	On Right Breast	2
Impediment of Speech	1	Itching Navel	1	In Throat	1
Impaired Sight	1	Jaundice	23	Lung Trouble	5
Impotency	1	Joints Stiff and Swollen	1	Malaria	3
Incoordination of Voluntary Muscles	1	Jerking of Entire Left Side of Muscles	1		
Indigestion	97				
Infantile Paralysis	17				

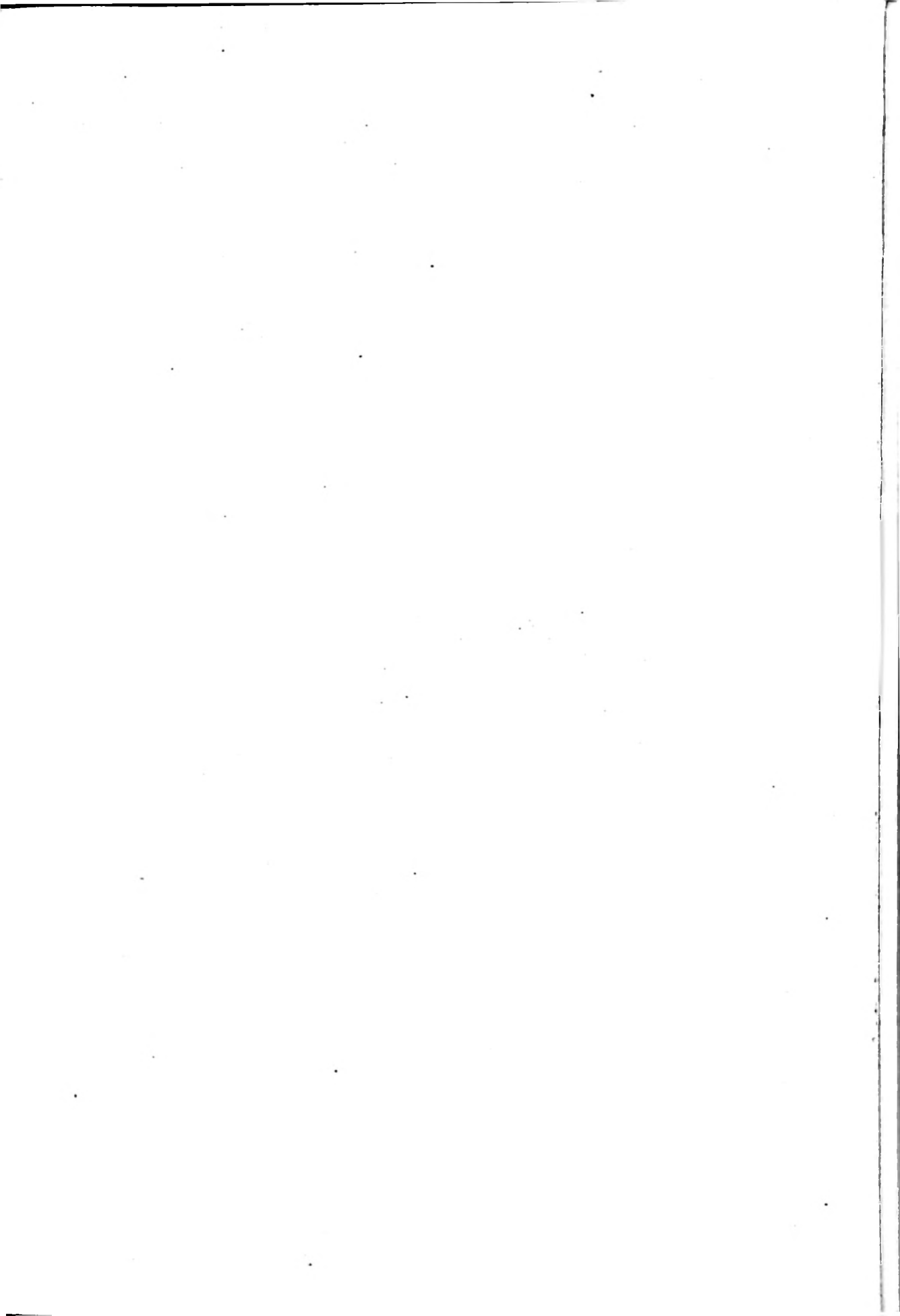
Malignant Growth in Groin and Back..	1	Right Arm and Shoulder	18	Colon	1
Malnutrition	2	Right Side	2	Head, Back, and Hips	1
Malta Fever	1	Left Side	1	Head	6
Mastoiditis	15	Left Arm	17	Legs	14
Left Side	1	Neck	3	Legs and Arms	3
Melancholia	7	Neck and Left Arm	1	Right Inguinal Region	1
Melena	1	Head, Neck and Arms	2	Left Side of Neck..	1
Menigitis	2	Right Shoulder	2	Right Hip and Leg	3
Menopause	1	Left Arm and Shoulder	2	Left Arm	2
Menorrhagia	5	Shoulders	5	Over Right Eye and Back of Head	2
Menstrual Disorders..	67	Hip and Legs	1	Eyeball	1
Mental Condition	24	Both Feet	2	Left Hip and Ankle	1
Depression	5	Shoulders and Arms	3	Right Eye	1
Meningeal Headaches	1	Left Arm and Hand	1	Neck and Scapula..	1
Measles	1	Entire Body	2	Left Ear, Eye, Arm, and Leg	1
Metorrhagia	25	Left Side of Face..	1	Right Side of Head and Shoulder	1
Migraine Headaches..	17	Neurasthenia	10	Lower Lumbar	20
Mitral Incompetency..	2	Night Sweats	3	Upper Dorsals	3
Mitral Stenosis	1	No Control of Urine..	1	Arms, Legs, and Shoulders	1
Muco-purulent Conjunctivitis	1	No Menstruation	1	Sacral Region	6
Multiple Sclerosis	3	Nocturnal Enuresis ..	12	Through Entire Body	4
Neuritis	3	Nocturea	2	Both Ears	3
Mumps	2	Nocturea Spondylitis..	1	Legs and Chest	2
Muscular Collapse	1	Numbness	2	Kidneys	3
Contraction of Left Shoulder and Head	1	Of Right Leg	1	Back, Hips and Legs	5
Contraction of Legs	1	Right Arm and Hand	1	Left Shoulder	5
Incoordination	3	Right Arm and Back	1	Neck	68
Condition of Arm..	1	Right Side	1	Dorsal Region	7
Rheumatism	3	Arms and Hands	1	Right Arm	4
Pains in Back	2	Right Arm and Left Leg	1	Epigastric Region..	1
Shaking of Left Arm	1	Fingers	2	Sacro-iliac Region ..	4
Atrophy	1	Hands	10	Back	24
Pain Both Sides of Neck, Arms, and Lower Limbs	1	Arms	5	Back, Bowels, and Kidneys	1
Twitching Over Entire Body	1	Mouth, Face, and Tongue	1	Stomach	11
Milk Leg	1	Right Arm	5	Side	6
Myelitis	1	Legs	6	Right Leg	4
Myalgia Lower Lumbar	2	Feet	5	Stomach and Bowels	1
Nasal Hemorrhages..	2	Fingers, Abdomen and Thigh	1	Lower Right Side..	1
Catarrh	4	Face	1	Right Arm and Shoulder	3
Ulcers	1	Numb Feeling Along Spinal Column	1	In Left Hip	7
Passage Stopped	1	Nose Bleed	1	In Coccyx	7
Discharge	2	Noises in Left Ear..	1	In Shoulders and Arms	15
Nausea	21	Obesity	8	In Right Side	4
Neck Drawn	1	Occipital Headaches..	39	In Right Temporal ..	1
Rigid	1	Soreness	11	In Pelvic Region..	3
Injury	2	Pains	1	In Arms, Legs and Feet	2
Nearsightedness	1	Oophoritis	1	Over Left Eye	1
Nephritis	5	Orbital Headaches	1	In Left Knee	4
Nervousness	566	Open Sore Following Appendicitis	1	In Chest	5
Nervous Breakdown..	28	Operation	1	In Spine	3
Indigestion	6	Osteomalacia of Wrist	1	In Right Renal Region	1
Melancholia	3	Of Head of Femur..	1	In Right Elbow	1
Psychosis	10	Of Lumbar and Sac. Region	1	In Arms and Neck..	2
Dyspepsia	2	Orchitis	3	In Eyes and Neck..	3
Disturbance	1	Otitis Media	4	In Head, Back and Hips	2
Debility	1	Ovarian Pains	6	In Middle Dorsals..	7
Cough	1	Trouble	5	In Extremities	1
Exhaustion	1	Cyst	2	In Lower Back	10
Neuralgia	21	Ovarian and Uterine Trouble	1	In Arm and Shoulder	6
Of Neck	2	Ovaritis	5	In Small of Back..	4
Head	2	Pain and Numbness in Legs	1	In Neck and	
Temple and Right Eye	1	Pain at Base of Skull	1		
Face	2	In Arches	1		
Neuritis	102	Chest	3		
Of Arms and Chest	3				
Right Arm	29				

Shoulders	10	Right Leg	7	Of Uterus	23
In Right Foot.....	1	Below Waist	2	Of Stomach	3
In Left Hip and		Left Foot	1	Of Scrotum	1
Thigh	2	Left Side	8	Of Abdomen	1
In Lumbar and		Epiglottis	2	Pressure Symptoms	
Sacral Region	6	Both Arms	8	in Neck	1
In Left Side and		Right Shoulder,		Profuse Menstruation	4
Back	3	Arm and Hand....	4	Prostate Trouble	3
In Left Breast.....	1	Right Arm	3	Protruding Piles	1
Above and Below		Left Leg and Foot..	6	Progressive Perni-	
Left Eye	1	Right Arm and		cious Anemia	1
Superior to Right		Both Legs	1	Psychic Neurosis	1
Ilium	1	Legs	5	Psychoses	16
In Left Sciatic		Both Legs and Feet	1	Psoriasis	29
Nerve	1	Left Leg and Foot	2	Pulmonary	
In Back of Neck....	8	From Neck Down....	2	Tuberculosis	2
In Region of Gall		Face, Larynx, and		Pus Discharge in	
Bladder	3	Arm	1	Urine	2
In Region of Left		Arms and Legs.....	16	Ptoses of Right Eye..	1
Ovary	3	Throat	1	Of Transverse	
In Region of Heart		Lower Extremities	1	Colon	1
In Eyes and		Bowels	2	Of Liver	1
Forehead	1	Paralysis	49	Of Kidneys	1
Over Right Kidney		Paralysis Agitans ..	2	Pyorrhea	1
In Right Side	4	Partial Paralysis ..	4	Quinzy	6
In Lower Spine	6	Of Right Hand....	4	Rapid Pulse	5
In Upper Right		Of Legs	4	Rapid Heart	3
Scapulae	1	Of Right Arm	2	Rash on Abdomen....	1
In Eyeballs	5	Of Left Arm and		On Legs and Arms	1
Between Scapulae ..	6	Leg	1	On Left Arm	1
In Lower Abdomen		Of Right Arm and		On Neck and Face..	2
and Back	2	Leg	1	Rectal Pains	2
In Right Abdominal		Of Left Leg	1	Rectocele	1
Region	3	Of Right Foot	1	Regurgitation	1
In Sacral Region....	6	Of Left Hand	1	Removal of Female	
In Lower Abdomen		Partial Loss of Vision		Generative Organs	1
and Groin	4	Right Eye	1	Renal Pains	3
In Lower Lumbar		Both Eyes	3	Renal Lethiasis	2
In Right Ear	1	Left Eye	1	Retention of Urine....	2
In Lower Lumbar		Partial Deafness	2	Retro Displacement	
and Knees	4	Partial Loss of Pul-		Of Uterus	2
In Right Shoulder..	6	monary Function	2	Reynaud's Disease ..	1
In Chest and		Passes Clots		Rheumatic Carpals ..	1
Shoulders	3	Regularly	1	Rheumatism	93
In Neck and Right		Pelvic Distress	3	Inflammatory	8
Arm	2	Pelvic Tumor	1	Of Heart	2
In Upper Cervicals		Peptic Ulcers	3	Of Left Shoulder....	1
In Right Lung	3	Periodic Pain in		Of Left Arm	2
In Arms	2	Abdomen	1	Of Left Leg	6
In Right Inguinal		Paralysis Right Leg	1	Of Right Leg	4
Region	3	Periods of		Of Arms, Shoulders	
Under Left Ribs....	2	Unconsciousness ..	1	and Knees	2
In Region of		Peritonitis	1	Of Arms	1
Appendix	4	Pertusis	3	Of Shoulders	2
In Back and Upper		Pernicious Anemia ..	2	Of Knees	7
Cervicals	2	Petit-mal	6	Of Left Hip	3
Pain and Numbness		Phlebitis	4	Of Right Hip	1
in Shoulders and		Phlegm in Throat....	1	Of Arms and Legs..	4
Arms	1	Photophobia	1	Of Lower	
Pain and Paralysis of		Piles	14	Extremity	1
Right Leg	1	Pimples on Back....	1	Of Right Shoulder,	
Pain and Cramps in		Pleurisy	23	Neck and Arm.....	1
Legs	1	Pneumonia	4	Of Left Hip and	
Pain and Swollen		Pneumonia, Double..	4	Leg	1
Joints	3	Pneumonia, Lobar ..	2	Rheumatic Fever	1
Pain and Weakness		Poison Ivy	2	Rhinitis	2
of Legs Below		Poliomyelitis	1	Retinitis of Left Eye	1
Knees	1	Polvuria	13	Rickets	3
Painful Menstruation		Poor Circulation	3	Right Side of Neck	
Palpitation	14	Poor Vision	4	Swollen	1
Palsy	5	Potts Disease	1	Right Knee and Leg	
Paralysis of Left Side		Prickling Sensation		Swollen	1
of Face	7	Over Entire Body	1	Right Leg ½ inch	
Both Limbs	3	Prolonged		Short	3
Right Side	11	Menstruation	1	Right Iliac Pains	1
Both Legs and		Prolapse of Abdom-		Right Leg Rigid	1
Right Arm	8	inal Organs	2		

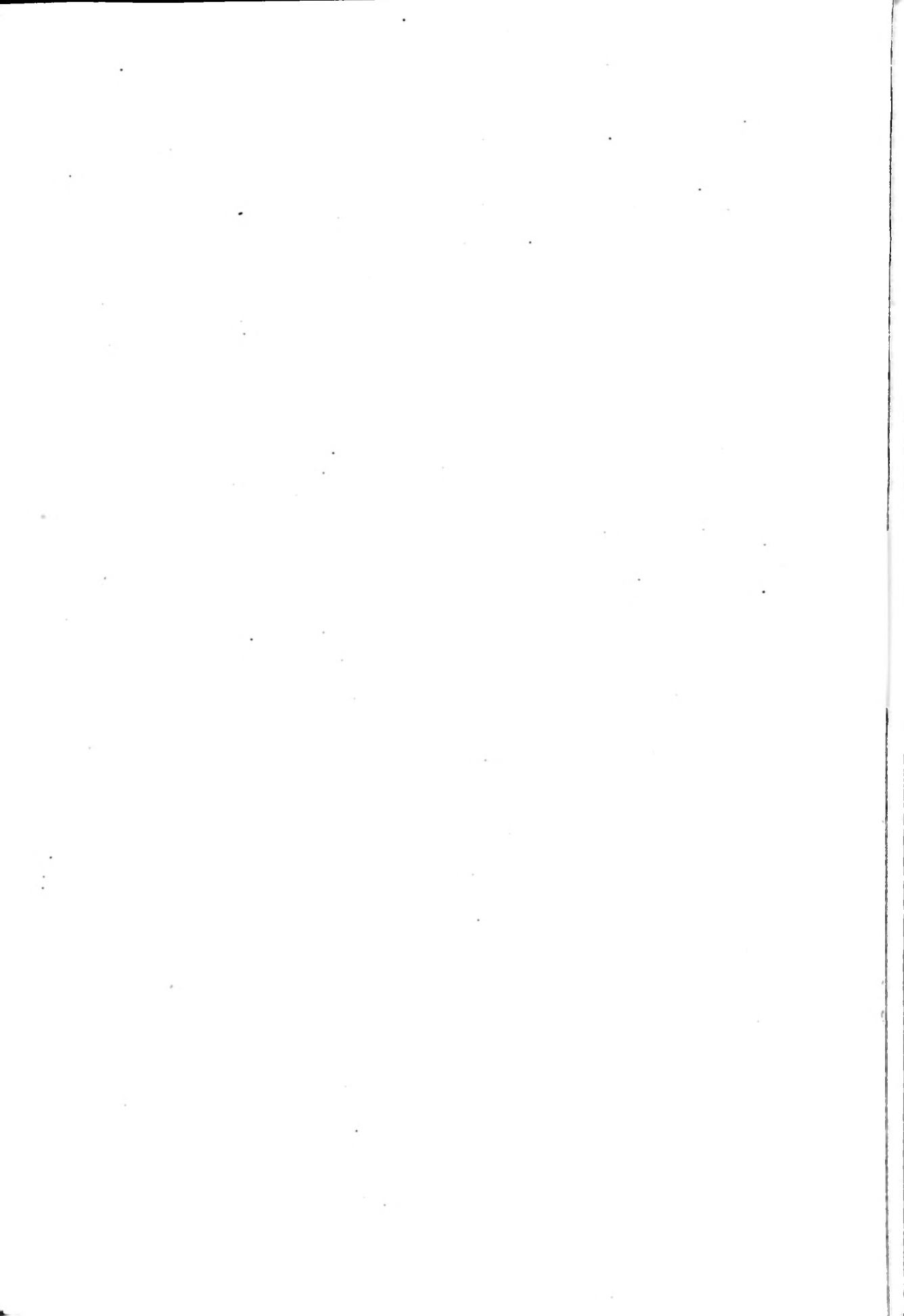
Right Ovaritis	1	Cramps	1	Stroke	1
Ringworm	4	Night Sweats	3	Stupor	1
Ring Sore at Tibia....	1	Inflamed Adenoids,		Sty	1
Ring of Ears	4	Tonsils and Sub-		Sub-normal Temper-	
Rose Cancer	1	lingual Glands	1	ature of Body....	1
Rose Fever	3	Catarrhal Condition	2	Sub-acute Appendi-	
Rotatory Scoliosis ...	4	Sexual Function		citis	1
Rotation of Both		Restored	1	Swelling of Ankles...	8
Eyes	2	Shaking of Head....	2	Of Right Leg	4
Roughness in Throat	2	Of Both Hands....	1	Right Knee	3
Rupture	4	Of Entire Body....	1	Lips	1
Running of Nose	1	Shaking Palsy	5	Ankles and Knees..	2
Of Ears	7	Shaking Palsy of		Testes	1
Running Sore, Right		Right Hand	2	Eyelids	1
Foot	1	Shell Shock	1	Feet	1
Left Ankle	1	Shingles	5	Arm	1
Ruptured Bladder	1	Sight Failing	1	Tongue	1
Sacro-Iliac Injury	1	Sinking Spells	2	Hands and Feet....	1
Sacro-Iliac Pains	7	Sinusitis	77	Right Side of Face	1
Scabby Eruptions	1	Sinus Trouble	35	Swelling and Burning	
Scaly Rash on Body..	2	Simple Goitre	1	of Feet	1
Scanty Urination	6	Sleeps Unsoundly ...	18	Sweating Around	
Scapular Pains	1	Slight Leakage of		Head, Even in	
Scarlet Fever	7	Heart	1	Cold Weather....	2
Sciatic Neuritis	1	Slight Paralysis Right		Sweet Taste in Mouth	1
Rheumatism	9	Leg and Arm	1	Syncope	9
Rheumatism, Left		Skin Eruption on		Syphilis	1
Leg	2	Hands	1	Tachca Cardia	6
Sciatica	142	Smallpox	1	Talking Continuously	1
Right Leg	12	Sneezing	2	Temporal Headaches..	2
Arms	1	Snorting Thru Nose..	1	Temporary Loss of	
Left Leg	9	Soreness of Legs....	2	Use of Arm and	
Left Hip	1	Between Shoulders	1	Hand	1
Left Hip and Leg...	2	In Eyeballs	1	Tenderness in Region	
St. Vitus Dance	2	In Lumbar Region..	4	of Coccyx	1
Salpingitis	1	Over Entire Body...	1	Head and Neck....	2
Sand in Kidneys	1	Of Chest	1	Iliac Region	1
Scrotal Hernia	1	In Side	3	Left Side of Coccyx	1
Scrotum Filled with		In Rectum	1	Tension of Spinal	
Serous Fluid	1	Of Base of Spine...	2	Muscles	1
Secondary Anemia		Of Mouth and Gums	1	Tetanus	1
Semi-consciousness ...	1	Sore Throat	11	Thoracic Pains	2
Seminal Discharge		Spasms	7	Throat Trouble	12
Sensation of Head		Spasms of Abdominal		Tic Douloureux	4
Being Full	1	Muscles	1	Thyroidectomy	1
Of Tightness		Spasmodic Contrac-		Trench Mouth	3
Around Head	1	tion of Right Side		Tightness of Spine ..	1
Sensitive Stomach	1	Face and Right		Ticking of Eyes	1
Sense of Pressure in		Eyelid	1	Tilted Pelvis	2
Chest	1	Spasmodic Torticollis	1	Testicles Undeveloped	1
Sensory Paralysis of		Spastic Contraction		Tingling Sensation	
Fingers	1	of Arms	1	Over Entire Body	1
Severe Bruise of Left		Spinal Meningitis	4	Tired Feeling	8
Hip	1	Spino-Pelvic Pain....	1	Tired and Sore	
Severe Pain in Breast	2	Spinal Curvature	1	Feeling	1
Around Face and		Tension	1	Tipped Uterus	1
Head	1	Stammering	4	Tonsilectomy	1
In Back	4	Staring Eyes	1	Tonsillitis	28
In Lower Lumbar...	3	Sterility	1	Tongue Coated with	
In Region of Coccyx	3	Stiffness and Sore-		White Circles....	1
Thruout Body	1	ness of Lumabr		Torn Ligaments in	
In Occipital Region	3	Region	3	Shoulder	1
In Stomach	1	Stiffness in Elbows...	1	Torticollis	32
In Knees	1	In All Joints and		Toxic Condition	4
In Lumbar Region..	4	Muscles	1	Goitre	2
At Beginning of		Of Right Arm....	1	Headache	1
Menstruation	1	Of Entire Back....	2	Transient Blindness..	1
Between Shoulders	4	Stiff Neck	30	Trauma of Cervical	
In Head and Hands	1	Knee	2	Region	1
In Left Eye	2	Back and Legs....	1	Trembling of Right	
Severe Headache	33	Lower Spine and		Arm	1
Kyphoses 7th Dor.		Left Leg	2	Tremors of Both	
to Sacrum	1	Right Knee	1	Hands	1
Mucous Discharge..	1	Stomach Trouble	202	Trifacial Paralysis ...	1
Backache	1	Stomatitis	1	Of Right Side	1
Cold	4	Strabismus	12	Trifacial Neuralgia...	9
Cough	1	Strained Back	5	Trouble in Head and	

Neck	1	Of Eyeball	1	Vision Affected	3
Traumatic Neurosis.....	1	Of Stomach	16	Violent Emesis	1
Tuberculosis	17	Of Throat	1	Vomiting	34
Of Bowels	1	Unable to Walk.....	7	Vomiting of Bile	1
Lungs	27	To Walk or Talk....	4	Warts on Arms, by	
Hips	3	To Move Arms	1	Hundreds	1
Kidneys	1	To Hold Head	1	Water on Brain	1
Spine	1	Erect	1	Watering of Eyes.....	3
Tumor	1	To Retain Urine.....	1	Water Rash Over	
Abdomen	1	To Urinate	1	Left Side of Face	1
Left Breast	1	To Sleep	7	Watery Pocket on	
Over Entire Body....	1	To Stand, Without		Elbow	1
Left Jaw	1	Taping Abdomen	1	Weakness of Eyes.....	21
Twist in Sacro-Iliac		Unconsciousness	12	Right Side	1
Joint	1	Unconsciousness upon		Legs	3
Twitching of Eyelids	4	Tipping Head		Right Leg	2
Facial Muscles	2	Backward	1	Over Entire Body....	3
Neck	1	Underweight	9	Right Arm	2
Head	1	Unilateral Paralysis..	1	Weak Heart	7
Upper Lip	1	Uric Acid Poisoning..	2	Bladder	1
Left Side of Face....	2	Urticaria	1	Stomach	4
Back	1	Uterine Hemorrhage..	4	Back	3
Mouth	1	Uterine Tumor	5	Lungs	1
Neck Muscles	1	Vaginal Trouble	2	Voice	1
Tongue	1	Ulcers	1	Eyes	4
Typhoid	4	Valvular Leakage	1	Muscles in Feet....	1
Ulceration of Left		Varicose Veins	28	Wrenched Neck	1
Leg	1	Ulcers	3	Whooping Cough	3
Ulcers	1	Vertigo	84	Withered Shoulder....	1
Of Leg	1	Vibration of Left		Wry Neck (torticollis)	20
Of Intestines	2	Foot on Floor....	1	Total	9,628

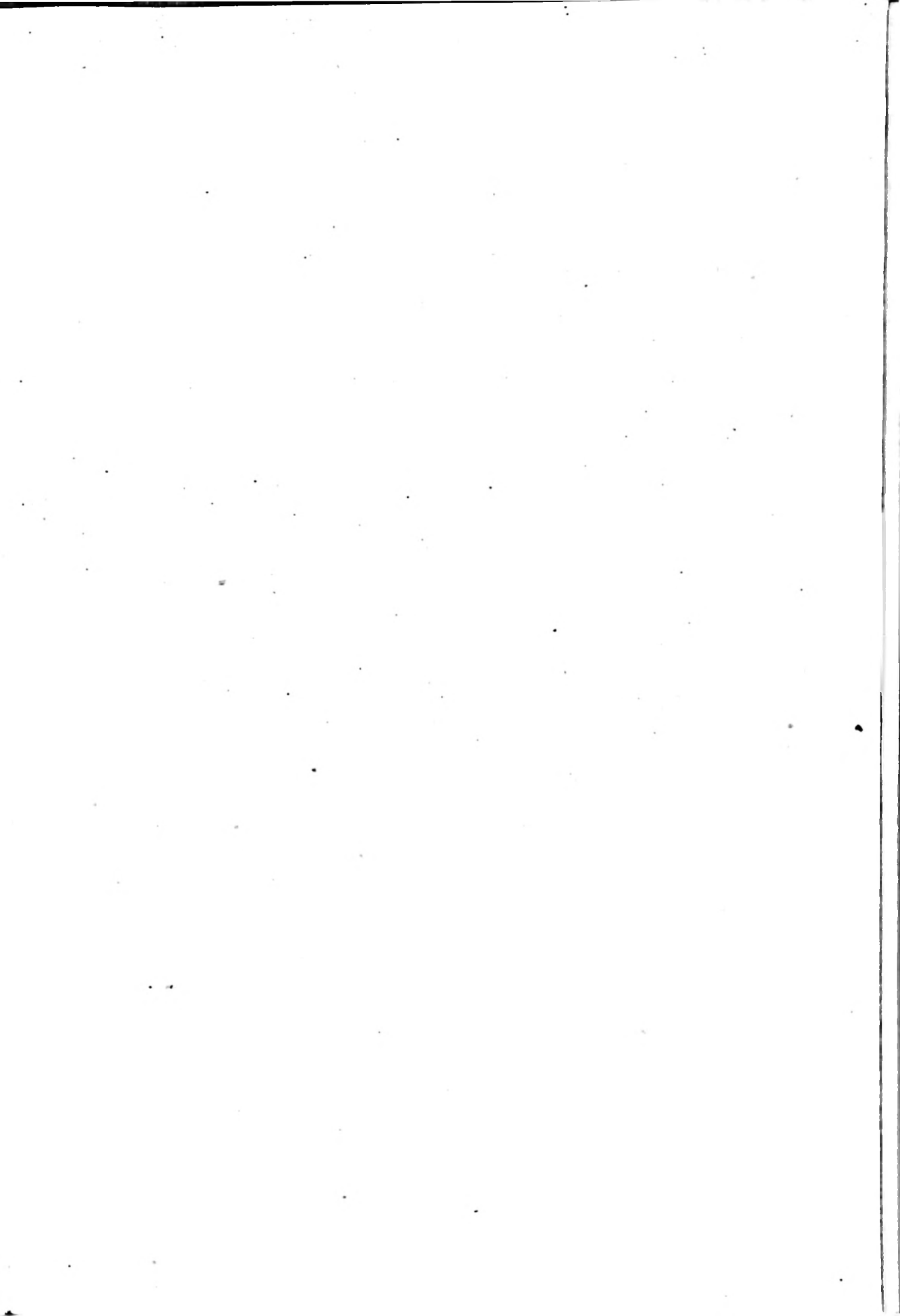
As listed, we have 9,628 "diseases" under the above titles. This averages 1.92 per person. It would be difficult to say whether this statement is correct or incorrect. If every patient, comprising this Report, had been examined by experts in every known diagnostic method, it still would be impossible to know whether it contained the elements of fact or not. One case might "report" 6 diseased names; each of which might be 6 symptoms of 1 disease. The main issue, tho, still remains paramount, viz.: that ONE location of adjustment corrected all the conditions named, regardless of location, thus proving the simplicity OF CAUSE as against the complexities OF DISEASES.

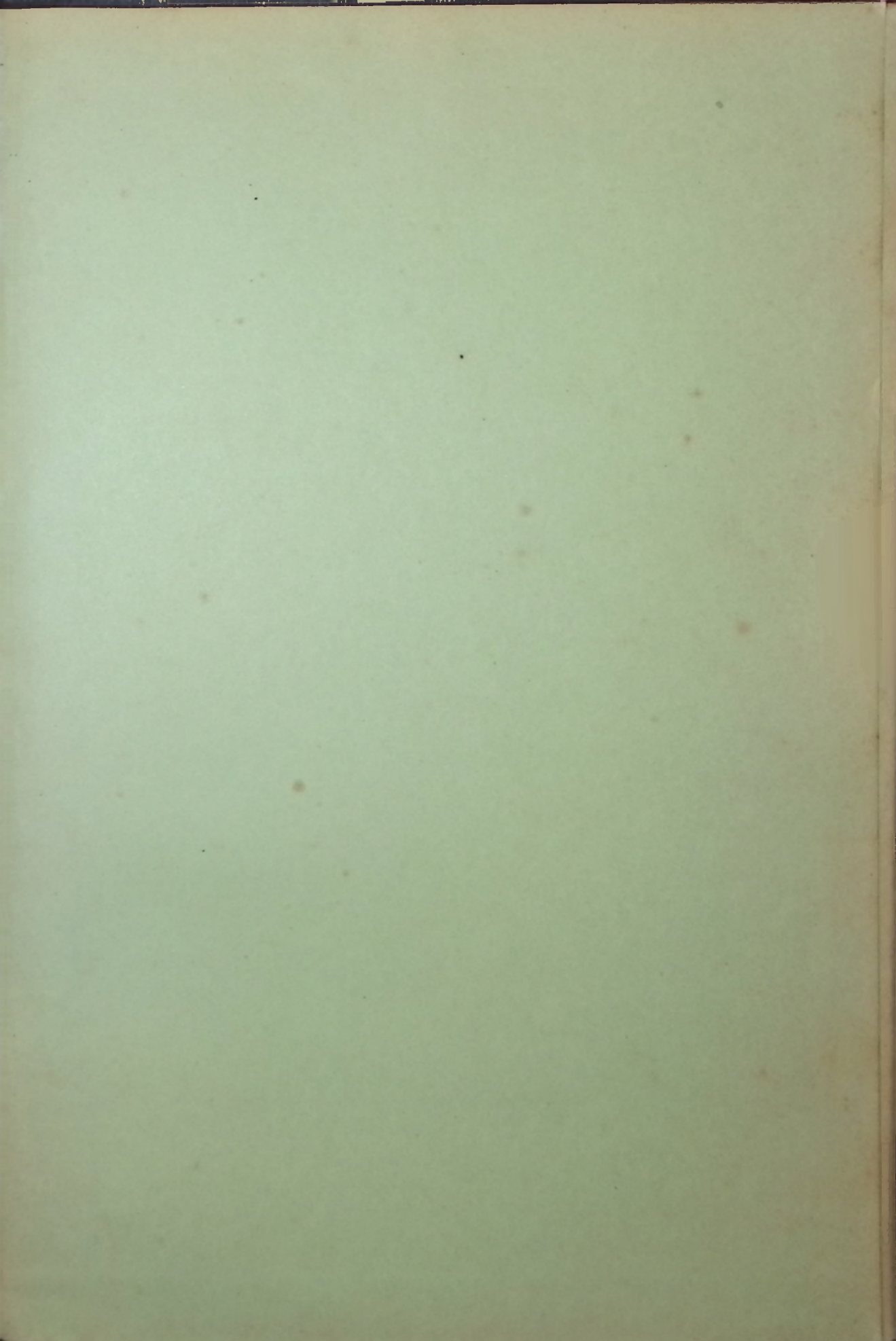












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